A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,
AND INSURANCE INDUSTRY PROFESSIONALS

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treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still in the limited provider network or delegated entity.

(d) Contracts between a limited provider network or delegated entity and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

(e) This section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

[Sections 1273.006-1273.050 reserved for expansion]

SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

Revised Law

Sec. 1273.001. DEFINITIONS. In this subchapter:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has the meaning assigned by Section 843.002.

(3) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee chooses to obtain benefits or services through:

(i) a health maintenance organization delivery network, including a limited provider network; or

(ii) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of health care services are provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization. (V.T.I.C. Art. 3.64, Sec. (a).)

Source Law

Art. 3.64. (a) In this article:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has

the meaning assigned by Section 2, Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code).

(3) "Insurance carrier" means an insurance company, group hospital service corporation, association, or organization authorized to do business in this state under this chapter or Chapter 8, 10, 11, 12, 13, 14, 15, 18, 19, 20, or 22 of this code.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee may choose to obtain benefits or services, or both benefits and services, through either a health maintenance organization delivery network, including a limited provider network, or through a non-network delivery system outside the health maintenance organization's health care delivery network, including a limited provider network, and that are administered through an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of the health care services may be provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization.

Revisor's Note

Section (a)(3), V.T.I.C. Article 3.64, refers to Chapter 3 of the Insurance Code. The relevant portions of Chapter 3, relating to authorization of domestic, foreign, and alien life, health, and accident insurance companies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care. (V.T.I.C. Art. 3.64, Sec. (b).)

Source Law

(b) An insurance carrier may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care.

Revised Law

Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance organization and an insurer may offer a blended contract. The use

of a blended contract is limited to point-of-service arrangements between a health maintenance organization and an insurer.

(b) A blended contract delivered, issued, or used in this state is subject to, and must be filed with the department for approval as provided by, Chapter 1701 and Section 1271.101. (V.T.I.C. Art. 3.64, Secs. (c), (d).)

Source Law

> (c) An insurance carrier and a health maintenance organization may offer a blended contract if indemnity benefits are combined with health maintenance organization benefits. The use of a blended contract is limited to point-of-service arrangements between an insurance carrier and a health maintenance organization.
>
> (d) A blended contract delivered, issued, or used in this state is subject to and must be filed with the department for approval as provided by Article 3.42 of this code and Section 9(a)(5), Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code).

Revisor's Note

Section (c), V.T.I.C. Article 3.64, provides in part that an insurer and a health maintenance organization may offer a blended contract "if indemnity benefits are combined with health maintenance organization benefits." The revised law omits the quoted language as unnecessary because "blended contract" is defined by Section (a)(1), Article 3.64, which is revised as Section 1273.001(1), as a document that "provides a combination of indemnity and health maintenance organization benefits."

Revised Law

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING PROVISIONS. Indemnity benefits and services provided under a point-of-service plan may be limited to those services described by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited

provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network. (V.T.I.C. Art. 3.64, Sec. (e).)

Source Law

> (e) Indemnity benefits and services provided under a point-of-service plan may be limited to those services as defined by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for the indemnity benefits may be higher than cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in limited provider networks, higher cost sharing may be imposed only when obtaining benefits or services outside the health maintenance organization delivery network.

Revised Law

Sec. 1273.005. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 3.64, Sec. (f).)

Source Law

> (f) The commissioner may adopt rules to implement this article.

[Sections 1273.006-1273.050 reserved for expansion]

SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

Revised Law

Sec. 1273.051. DEFINITIONS. In this subchapter:

(1) "Employee" means an individual employed by an employer.

(2) "Health benefit plan" has the meaning assigned by Section 1501.002.

(3) "Non-network plan" means health benefit coverage that provides an enrollee an opportunity to obtain health care services through a health delivery system other than a health maintenance organization delivery network, as defined by Section 843.002.

(4) "Point-of-service plan" means an arrangement under which an enrollee chooses to obtain benefits or services through:

(A) a health maintenance organization delivery network, including a limited provider network; or

(B) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services.

(5) "Preferred provider benefit plan" means an insurance policy issued under Chapter 1301.

(6) "Small employer health benefit plan" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 26.02, Subdivs. (10), (11), (31), as amended Acts 77th Leg., R.S., Ch. 608, (32), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.09, Sec. (a).)

Source Law

Art. 26.02. In this chapter:

(10) "Employee" means any individual employed by an employer.

(11) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(B) credit-only insurance;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation or similar insurance;

(L) automobile medical payment insurance coverage;

(M) jointly managed trusts

authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) short-term major medical contracts;

(Q) liability insurance, including general liability insurance and automobile liability insurance;

(R) other coverage that is:

(i) similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and

(ii) specified in federal regulations;

(S) coverage for on-site medical clinics; or

(T) coverage that provides other limited benefits specified by federal regulations.

(31) "Small employer health benefit plan" means a plan developed by the commissioner under Subchapter E of this chapter or any other health benefit plan offered to a small employer in accordance with Article 26.42(c) or 26.48 of this code.

(32) "Small employer health benefit plan" means a plan developed by the commissioner under Subchapter E of this chapter or any other health benefit plan offered to a small employer in accordance with Article 26.42(c) or 26.48 of this code.

Art. 26.09. (a) In this article:

(1) "Non-network plan" means health benefit coverage that provides an enrollee an opportunity to obtain health care services through a health delivery system other than a health maintenance organization delivery network, as defined by Section 2, Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code).

(2) "Point-of-service plan" means an arrangement under which an enrollee may choose to obtain benefits and services, or both benefits and services, through either a health maintenance organization delivery network, including a limited provider network, or through a non-network delivery system outside the health maintenance organization's health care delivery network, including a limited provider network, and that are administered through an indemnity benefit arrangement for the cost of health care services.

(3) "Preferred provider benefit plan" means an insurance policy issued and licensed under Article 3.70-3C of this code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997.

Revisor's Note

(1) Subdivision (11), V.T.I.C. Article 26.02, defines "health benefit plan," and Subdivision (31),

V.T.I.C. Article 26.02, as amended by Chapter 608, Acts of the 77th Legislature, Regular Session, 2001, and Subdivision (32), V.T.I.C. Article 26.02, as amended by Chapter 823, Acts of the 77th Legislature, Regular Session, 2001, define "small employer health benefit plan." The substance of those definitions is revised in Section 1501.002, and the revised law substitutes a cross-reference to that section for the substance of the definitions.

(2) Subsection (a)(3), V.T.I.C. Article 26.09, defines "preferred provider benefit plan" as an insurance policy "issued and licensed" under V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Chapter 1301. The revised law omits the reference to "licensed" as inaccurate and unnecessary. An insurance policy is not "licensed" under Article 3.70-3C, and the requirement that the policy be "issued" under that article is sufficient to ensure that the policy complies with the requirements of that article.

Revised Law

Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN REQUIRED. (a) Except as provided by Subsection (b), if the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage must offer to all eligible employees, at the time of enrollment and at least annually, the opportunity to obtain coverage through a non-network plan.

(b) Each health maintenance organization to which Subsection (a) applies may enter into an agreement designating one or more of those health maintenance organizations to offer the coverage required by Subsection (a) for eligible employees of the

employer. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

Source Law

> (b) If the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage under the employer's health benefit plan must offer to all eligible employees the opportunity to obtain health benefit coverage through a non-network plan at the time of enrollment and at least annually, unless all health maintenance organizations offering coverage under the employer's health benefit plan enter into an agreement designating one or more of those health maintenance organizations to offer that coverage. . . .

Revised Law

Sec. 1273.053. COVERAGE OPTIONS. The coverage required to be offered under this subchapter may be provided through:

(1) a point-of-service plan;

(2) a preferred provider benefit plan; or

(3) any coverage arrangement that provides an enrollee with access to services outside the health maintenance organization's or limited provider network's delivery network.

(V.T.I.C. Art. 26.09, Sec. (b) (part).)

Source Law

> (b) . . . The coverage required under this subsection may be provided through a point-of-service contract, a preferred provider benefit plan, or any coverage arrangement that allows an enrollee to access services outside the health maintenance organization's or limited provider network's delivery network.

Revisor's Note

Section (b), V.T.I.C. Article 26.09, refers to a "point-of-service contract." Throughout this subchapter, the revised law substitutes "point-of-service plan" for "point-of-service contract" because "point-of-service plan" is the term defined under Section (a)(2), V.T.I.C. Article 26.09, revised as Section 1273.051(4).

Revised Law

Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium for coverage required to be offered under this subchapter must be

based on the actuarial value of that coverage and may be different from the premium for coverage otherwise offered by the health maintenance organization. (V.T.I.C. Art. 26.09, Sec. (c).)

Source Law

> (c) The premium for coverage required to be offered under this article shall be based on the actuarial value of that coverage and may be different than the premium for the health maintenance organization coverage.

Revised Law

Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different cost-sharing provisions may be imposed for a point-of-service plan offered under this subchapter, and those provisions may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

(b) An employee who chooses the non-network plan is responsible for any additional costs for the non-network plan, and the employer may impose a reasonable administrative fee for providing the non-network plan. (V.T.I.C. Art. 26.09, Secs. (d), (e).)

Source Law

> (d) Different cost-sharing provisions may be imposed for a point-of-service contract offered under this article and may be higher than cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in limited provider networks, higher cost sharing may be imposed only when obtaining benefits or services outside the health maintenance organization delivery network.
>
> (e) Any additional costs for the non-network plan are the responsibility of the employee who chooses the non-network plan, and the employer may impose a reasonable administrative cost for providing the non-network plan option.

Revised Law

Sec. 1273.056. EXCEPTIONS. This subchapter does not apply to:

(1) a small employer health benefit plan; or

(2) a group model health maintenance organization that

is a nonprofit, state-certified health maintenance organization that:

(A) provides the majority of its professional services through a single group medical practice that is governed by a board composed entirely of physicians; and

(B) educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association. (V.T.I.C. Art. 26.09, Sec. (f).)

Source Law

(f) This article does not apply to:

(1) a small employer health benefit plan; or

(2) a group model health maintenance organization that is a nonprofit, state-certified health maintenance organization that provides the majority of its professional services through a single group medical practice that is governed by a board composed entirely of physicians and that educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accrediting Council on Graduate Medical Education or the American Osteopathic Association.

Revisor's Note

Section (f)(2), V.T.I.C. Article 26.09, refers to the "Accrediting Council on Graduate Medical Education." The revised law substitutes "Accreditation Council on Graduate Medical Education" because that is the proper name of that organization.

Revised Law

Sec. 1273.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 26.04 (part).)

Source Law

Art. 26.04. The commissioner shall adopt rules as necessary to implement this chapter and . . . .

[Chapters 1274-1300 reserved for expansion]

SUBTITLE D. PREFERRED PROVIDER BENEFIT PLANS

CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1301.008-1301.050 reserved for expansion]

SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1301.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term does not include a physician.

(2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(3) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code.

(4) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

(5) "Insurer" means a life, health, and accident

insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(6) "Physician" means a person licensed to practice medicine in this state.

(7) "Practitioner" means a person who practices a healing art and is a practitioner described by Section 1451.001 or 1451.101.

(8) "Preferred provider" means a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

(9) "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

(10) "Service area" means a geographic area or areas specified in a health insurance policy or preferred provider contract in which a network of preferred providers is offered and available. (V.T.I.C. Art. 3.70-3C, Secs. 1(2), (3), (4), (5), (6), (8), (9), (10), (13), 2 (part), as added Acts 75th Leg., R.S., Ch. 1024; Art. 3.70-3C, Sec. 1, as added Acts 75th Leg., R.S., Ch. 1260.)

Source Law

> [Art. 3.70-3C, as added Acts 75th Leg., R.S., Ch. 1024]
>
> (2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.
>
> (3) "Health care provider" or "provider" means any practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician.
>
> (4) "Hospital" means a licensed public or private institution as defined in Chapter 241, Health

and Safety Code, or in Subtitle C, Title 7, Health and Safety Code.

(5) "Institutional provider" means a hospital, nursing home, or any other medical or health-related service facility caring for the sick or injured or providing care for other coverage which may be provided in a health insurance policy.

(6) "Insurer" means any life, health, and accident; health and accident; or health insurance company or company operating pursuant to Chapter 3, 10, 20, 22, or 26 of this code authorized to issue, deliver, or issue for delivery in this state health insurance policies, certificates, or contracts.

(8) "Physician" means anyone licensed to practice medicine in the State of Texas.

(9) "Practitioner" means a person who practices a healing art and is a practitioner described by:

(A) Section 2(B), Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code); or

(B) Article 21.52 of this code.

(10) "Preferred provider" means a physician, practitioner, hospital, institutional provider, or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy, certificate, or contract.

(13) "Service area" means a geographic area or areas set forth in the health insurance policy or preferred provider contract in which a network of preferred providers is offered and available.

Sec. 2. This article applies to any preferred provider benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage which is different from the basic level of coverage provided by the health insurance policy if the insured uses a preferred provider. . . .

Art. 3.70-3C [as added Acts 75th Leg., R.S., Ch. 1260]

Sec. 1. In this article:

(1) "Preferred provider" means a physician, advanced practice nurse, physician assistant, or other health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy, certificate, or contract.

(2) "Preferred provider benefit plan" means a benefit plan through which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured uses a preferred provider.

Revisor's Note

(1) Section 1(6), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to Chapter 3 of the

Insurance Code. The pertinent portions of Chapter 3, relating to organization of entities that may write health insurance policies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

(2) Section 1(10), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, in part defines "preferred provider" as a "physician, practitioner, hospital, institutional provider, or health care provider." The revised law omits the references to "practitioner," "hospital," and "institutional provider" because each of those entities is explicitly listed or clearly included within the meaning of "health care provider" under Section 1(3) of Article 3.70-3C.

(3) Section 1(1), V.T.I.C. Article 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, in part defines "preferred provider" as a "physician, advanced practice nurse, physician assistant, or other health care provider." The revised law omits the references to "advanced practice nurse" and "physician assistant" because each of those entities is a practitioner described by Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), revised as Section 1451.001 of this code. As such, each of those entities is included within the meaning of "health care provider" under Section 1(3), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, and the revised law definition of "preferred provider" specifically lists health care providers.

Revised Law

Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS. This chapter does not apply to a provision for dental care benefits in a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 2 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 2. . . . This article does not apply to provisions for dental care benefits in any health insurance policy.

Revised Law

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS PERMITTED. A health insurance policy that provides different benefits from the basic level of coverage for the use of preferred providers and that meets the requirements of this chapter is not:

(1) unjust under Chapter 1701;

(2) unfair discrimination under Subchapter A or B, Chapter 544; or

(3) a violation of Subchapter B or C, Chapter 1451. (V.T.I.C. Art. 3.70-3C, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 3. (a) A health insurance policy that includes different benefits from the basic level of coverage for the use of preferred providers shall not be considered unjust under Article 3.42 of this code, or unfair discrimination under Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, 1995, or Article 21.21-8 of this code or to violate Subsection (B), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), or Article 21.52 of this code, if it meets the requirements of this section.

Revisor's Note

Section 3(a), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, provides that a health insurance policy establishing a preferred provider benefit plan does not violate certain provisions of law relating to unjust policy provisions, unfair discrimination, and selection of practitioners if the policy meets the

requirements of "this section," meaning Section 3, Article 3.70-3C. However, the portion of Section 3 revised as Section 1301.004 requires a preferred provider benefit plan to comply with "this article," meaning all of Article 3.70-3C. Accordingly, the revised law refers to this chapter, rather than the portions of this chapter that were derived from Section 3, Article 3.70-3C.

Revised Law

Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED. Each preferred provider benefit plan offered in this state must comply with this chapter. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(l) . . . All preferred provider insurance benefit plans offered in this state shall comply with the requirements of this article.

Revised Law

Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) If services are not available through a preferred provider within the service area, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(c) Subsection (b) does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience. (V.T.I.C. Art. 3.70-3C, Sec. 8, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 8. (a) Any insurer offering a preferred provider benefit plan must ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.
>
> (b) If services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as the preferred providers would have been reimbursed had the insured been treated by them. Nothing in this subsection requires reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience.

Revised Law

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. (V.T.I.C. Art. 3.70-3C, Sec. 3(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (d) Insurers which market a preferred provider benefit plan must contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner assuring both availability and accessibility of adequate personnel, specialty care, and facilities.

Revised Law

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter; and

(2) ensure reasonable accessibility and availability of preferred provider benefits and basic level benefits to residents of this state. (V.T.I.C. Art. 3.70-3C, Sec. 9, as added

Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 9. The commissioner shall adopt rules as necessary to implement the provisions of this article and to ensure reasonable accessibility and availability of preferred provider and basic level benefits to Texas citizens.

Revisor's Note

Section 9, V.T.I.C. Article 3.70-3C, refers to "Texas citizens." The revised law substitutes "residents" for "citizens" because, in the context of this section, "citizen" and "resident" are synonymous, and "resident" is more commonly used.

[Sections 1301.008-1301.050 reserved for expansion]

SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

Revised Law

Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An insurer shall afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers:

(1) are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy; and

(2) comply with the terms established by the insurer for designation as preferred providers.

(b) An insurer may not unreasonably withhold a designation as a preferred provider.

(c) An insurer shall give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation.

(d) Unless otherwise limited by this code, this section does

not prohibit an insurer from rejecting a physician's or health care provider's application for designation based on a determination that the preferred provider benefit plan has sufficient qualified providers. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(1), (4), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (b)(1) Physicians, practitioners, institutional providers, and health care providers other than physicians, practitioners, and institutional providers, if such other health care providers are included by the insurer as preferred providers, licensed to treat injuries or illnesses or to provide services covered by the health insurance policy that comply with the terms and conditions established by the insurer for designation as preferred providers may apply for and shall be afforded a fair, reasonable, and equivalent opportunity to become preferred providers. Such designation shall not be unreasonably withheld.
>
> (4) The insurer must give a physician or health care provider not designated on initial application written reasons for denial of the designation; however, unless otherwise limited by this code, this section does not prohibit an insurer from rejecting an application from a physician or health care provider based on a determination that the preferred provider benefit plan has sufficient qualified providers.

Revisor's Note

(1) Section 3(b)(1), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to "physicians [and] practitioners"; similar phrases appear in subsequent sections of Article 3.70-3C. Throughout this chapter, the revised law omits such references to a "physician" as unnecessary. Section 1(9), Article 3.70-3C, in part defines "practitioner" as a person described as a practitioner under Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code). That section, which is revised in relevant part as Section 1451.001, describes a "Doctor of Medicine" licensed in Texas as a practitioner. "Doctor of Medicine" and "physician" are synonymous under Section 104.003(b), Occupations

Code.

(2) Section 3(b)(1), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to the "terms and conditions" established by an insurer for designation as a preferred provider; subsequent sections also use that phrase. Throughout this chapter, the revised law omits references to a "condition" because "condition" is included within the meaning of "term."

Revised Law

Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a preferred provider benefit plan may not refuse a request made by a physician participating as a preferred provider under the plan and an advanced practice nurse or physician assistant to have the advanced practice nurse or physician assistant included as a preferred provider under the plan if:

(1) the advanced practice nurse or physician assistant is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code; and

(2) the advanced practice nurse or physician assistant meets the quality of care standards previously established by the insurer for participation in the plan by advanced practice nurses and physician assistants. (V.T.I.C. Art. 3.70-3C, Sec. 2, as added Acts 75th Leg., R.S., Ch. 1260.)

Source Law

Sec. 2. If an advanced practice nurse or physician assistant is authorized to provide care under Section 3.06(d)(5) or (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), by a physician participating as a preferred provider under a preferred provider benefit plan, that plan may not refuse a request made by the physician and physician assistant or advanced practice nurse to have the physician assistant or advanced practice nurse included as a preferred provider by the plan unless the physician assistant or advanced practice nurse fails to meet the quality of care standards previously established by the preferred provider benefit plan for participation in the plan by advanced practice nurses and physician assistants.

Revisor's Note

(1) Section 2, V.T.I.C. Article 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, refers to Sections 3.06(d)(5) and (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Those statutes were codified in 1999 as Subchapter B, Chapter 157, Occupations Code. The revised law is drafted accordingly.

(2) Section 3, V.T.I.C. Article 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, prohibits a preferred provider benefit plan from taking certain action in relation to an advanced practice nurse or physician assistant because those practitioners are "not identified under Section 3, Article 21.52, Insurance Code." However, Chapter 428, Acts of the 76th Legislature, Regular Session, 1999, subsequently added those practitioners to Section 3, Article 21.52, and thus impliedly repealed Section 3, V.T.I.C. Article 3.70-3C. Therefore, the revised law omits Section 3, V.T.I.C. Article 3.70-3C. The omitted law reads:

> Sec. 3. A preferred provider benefit plan may not refuse to contract with an advanced practice nurse or physician assistant to be included in the plan's provider network, refuse to reimburse the advanced practice nurse or physician assistant for covered services, or otherwise discriminate against the advanced practice nurse or physician assistant because the advanced practice nurse or physician assistant is not identified under Section 3, Article 21.52, Insurance Code.

Revised Law

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED PROVIDER. (a) An insurer that does not designate a practitioner as a preferred provider shall provide a reasonable mechanism for reviewing that action. The review mechanism must incorporate, in an advisory role only, a review panel.

(b) A review panel must be composed of at least three individuals selected by the insurer from a list of participating practitioners and must include one member who is a practitioner in the same or similar specialty as the affected practitioner, if available. The practitioners contracting with the insurer in the applicable service area shall provide the list of practitioners to the insurer.

(c) On request, the insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(2), (3), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (2) If a designation as a preferred provider is withheld relating to a physician or practitioner, the insurer shall provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel. Any recommendation of the panel shall be provided on request to the affected physician or practitioner. In the event of an insurer determination contrary to any recommendation of the panel, a written explanation of the insurer's determination shall also be provided on request to the affected physician or practitioner.
>
> (3) The review panel shall be composed of not less than three individuals selected by the insurer from a list of the physicians or practitioners contracting with the insurer and shall include one member who is a physician or practitioner in the same or similar specialty as the affected physician or practitioner, if available. The list of physicians or practitioners is to be provided to the insurer by the physicians or practitioners contracting with the insurer in the applicable service area.

Revised Law

Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider benefit plan, an insurer shall immediately notify each practitioner in the plan's service area of the insurer's intent to offer the plan and of the opportunity to participate. The notification must be made by publication or in writing to each practitioner.

(b) After establishing a preferred provider benefit plan,

an insurer shall annually provide notice of and an opportunity to participate in the plan to practitioners in the plan's service area who do not participate in the plan.

(c) On request, an insurer shall provide to any physician or health care provider information concerning the application process and qualification requirements for participation as a preferred provider in the plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (c) Any insurer, when sponsoring a preferred provider benefit plan, shall immediately notify, by publication or in writing to each physician and practitioner, all physicians and practitioners in the geographic area covered by the plan of its intent to offer such a plan and of the opportunity to participate. Such notice and opportunity shall be provided on a yearly basis thereafter to noncontracting physicians and practitioners in the geographic area covered by the plan. The insurer shall on request make available to any physician or health care provider information concerning the application process and qualification requirements for participation as a provider in the plan.

Revisor's Note

Section 3(c), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to "the geographic area covered by the plan." The revised law substitutes "the plan's service area" for the quoted language because "service area" is the defined term under Section 1(13), Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.001(10).

Revised Law

Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract under a preferred provider benefit plan between an insurer and a physician or other practitioner or a physicians' group must have a mechanism for resolving complaints initiated by an insured, a physician or other practitioner, or a physicians' group.

(b) A complaint resolution mechanism must provide for

reasonable due process that includes, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b). (V.T.I.C. Art. 3.70-3C, Sec. 3(f), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (f) Every contract by an insurer with a physician, physicians group, or practitioner shall have a mechanism for the resolution of complaints initiated by the insured, physicians, physicians groups, or practitioners. Such mechanism shall provide for reasonable due process which includes, in an advisory role only, a review panel selected in the manner described in Subsection (b)(3) of this section.

Revised Law

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurer or third-party administrator may not reimburse a physician or other practitioner, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third-party administrator has contracted with either:

(A) the physician or other practitioner, institutional provider, or organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the physician or other practitioner, institutional provider, or organization of physicians and health care providers;

(2) the physician or other practitioner, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third-party administrator has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a

contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner or the Texas Workers' Compensation Commission under this code to request and obtain information.

(c) An insurer or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542; and

(2) is subject to administrative penalties under Chapters 82 and 84. (V.T.I.C. Art. 3.70-3C, Sec. 7A, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 7A. (a) An insurer or third party administrator may not reimburse a physician, practitioner, hospital, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third party administrator has contracted with either:

(A) the physician, practitioner, hospital, institutional provider, organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and such organization has contracted with the health care preferred provider;

(2) the physician, practitioner, hospital, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third party administrator has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority and prior adequate notification of the other contracting parties. This subsection does not affect the authority of the commissioner or the Texas Workers' Compensation Commission under this code to request and obtain information.

(c) An insurer or third party administrator who violates this section commits an unfair claim settlement practice in violation of Article 21.21-2 of

this code and is also subject to administrative penalties under Articles 1.10 and 1.10E of this code.

Revisor's Note

Section 7A(a), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "hospital [or] institutional provider." The revised law omits the reference to "hospital" because "hospital" is included within the meaning of "institutional provider" under Section 1(5), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.001(4).

Revised Law

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW PROCESS. (a) Before terminating a contract with a preferred provider, an insurer shall:

(1) provide written reasons for the termination; and

(2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving:

(A) imminent harm to a patient's health;

(B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine; or

(C) fraud or malfeasance.

(b) The review mechanism described by Subsection (a)(2) must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days.

(c) The insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) on request, a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

(d) On request, an insurer shall make an expedited review available to a practitioner whose participation in a preferred provider benefit plan is being terminated. The expedited review process must comply with rules established by the commissioner. (V.T.I.C. Art. 3.70-3C, Sec. 3(g), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (g) Before terminating a contract with a preferred provider, the insurer shall provide written reasons for the termination. Prior to termination of a physician or practitioner, but within a period not to exceed 60 days, the insurer shall, on request, provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel selected in the manner described in Subsection (b)(3) of this section, except in cases in which there is imminent harm to a patient's health or an action by a state medical or other physician licensing board or other government agency that effectively impairs a physician's or practitioner's ability to practice medicine or in cases of fraud or malfeasance. Any recommendation of the panel shall be provided to the affected physician or practitioner. In the event of an insurer determination contrary to any recommendation of the panel, a written explanation of the insurer's determination shall also be provided on request to the affected physician or practitioner. On request, an expedited review process shall be made available to a physician or practitioner who is being terminated. The expedited review process shall comply with rules established by the commissioner.

Revised Law

Sec. 1301.058. ECONOMIC PROFILING. An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs. (V.T.I.C. Art. 3.70-3C, Sec. 3(h), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(h) An insurer that conducts, uses, or relies on economic profiling to admit or terminate physicians or health care providers shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

Revised Law

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer. (V.T.I.C. Art. 3.70-3C, Secs. 1(12), 3(i), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

[Sec. 1]

(12) "Quality assessment" means a mechanism which is in place or put into place and utilized by an insurer for the purposes of evaluating, monitoring, or improving the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with that delivered by an ordinary, reasonable, prudent physician or health care provider under the same or similar circumstances.

[Sec. 3]

(i) No insurer shall engage in quality assessment except through a panel of not less than three physicians selected by the insurer from among a list of physicians contracting with the insurer, which list is to be provided by the physicians contracting with the insurer in the applicable service area.

Revised Law

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge. (V.T.I.C. Art. 3.70-3C, Sec. 3(k), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (k) A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge.

Revised Law

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that either the insurer or the preferred provider organization on the insurer's behalf will comply with the notice requirements and other requirements imposed on the insurer by this subchapter.

(b) An insurer that enters into an agreement with a preferred provider organization under this section shall meet the requirements of this chapter or ensure that those requirements are met. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (l) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that the notice and other insurer requirements of this section may be complied with by either the insurer or the preferred provider organization on the insurer's behalf. If an insurer enters into an agreement with a preferred provider organization under this section, it is the insurer's responsibility to meet the requirements of this article or to assure that the requirements are met. . . .

Revised Law

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS AND PODIATRISTS. A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;

(3) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(4) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3(n), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (n) A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:
>
> (1) the podiatrist may request, and the insurer shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;
>
> (2) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and
>
> (3) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

Revised Law

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient. (V.T.I.C. Art. 3.70-3C, Sec. 3B, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 3B. (a) In this section, "hospitalist" means a physician who:
>
> (1) serves as physician of record at a hospital for a hospitalized patient of another physician; and
>
> (2) returns the care of the patient to that other physician at the end of the patient's hospitalization.
>
> (b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Revised Law

Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF CLAIMS. Subject to Subchapter C, a preferred provider contract must provide for payment to a physician or health care provider for health care services and benefits provided to an insured under the contract and to which the insured is entitled under the terms of the contract not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (m) . . . A preferred provider contract must include a provision for payment to the physician or health care provider for covered services that are rendered to insureds under the contract not later than the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim or, if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer. For purposes of this subsection, "covered services" means health care

services and benefits to which an insured is entitled under the terms of the contract.

Revisor's Note

Section 3(m), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, prescribes certain provisions relating to payment for covered services that must be contained in a contract between an insurer and a preferred provider. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, was amended by the addition of Section 3A by Chapter 1343, Acts of the 76th Legislature, Regular Session, 1999. Section 3A, which is revised as Subchapter C of this chapter, provides for payment of certain "clean claims" submitted by a preferred provider. Section 312.014(a), Government Code, provides that "[i]f statutes enacted at . . . different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails." Thus, as the later enactment, Section 3A prevails over Section 3(m) to the extent of any conflict. Accordingly, the revised law includes a reference to Subchapter C.

Revised Law

Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY PROHIBITED. A preferred provider contract may not require any physician, health care provider, or physicians' group to execute a hold harmless clause to shift the insurer's tort liability resulting from the insurer's acts or omissions to the preferred provider. (V.T.I.C. Art. 3.70-3C, Sec. 3(j), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(j) A preferred provider contract may not require any health care provider, physician, or physicians group to execute hold harmless clauses in order to shift the insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

Revised Law

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. An insurer may not engage in any retaliatory action against a physician or health care provider, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract, because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(b), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (b) No insurer shall engage in any retaliatory action against a physician or health care provider, including termination of or refusal to renew a contract, because the physician or provider has, on behalf of an insured, reasonably filed a complaint against the insurer or has appealed a decision of the insurer.

Revised Law

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An insurer may not, as a condition of a preferred provider contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a person designated by a patient, information or an opinion:

(1) regarding the patient's health care, including the patient's medical condition or treatment options; or

(2) in good faith regarding the provisions, terms, requirements, or services of the health insurance policy as they relate to the patient's medical needs.

(b) An insurer may not in any way penalize, terminate the participation of, or refuse to compensate for covered services a physician or health care provider for discussing or communicating with a current, prospective, or former patient, or a person

designated by a patient, pursuant to this section. (V.T.I.C. Art. 3.70-3C, Sec. 7(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(c)(1) An insurer shall not, as a condition of a contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from:

(A) discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding that patient's health care, including but not limited to the patient's medical condition or treatment options; or

(B) discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient.

(2) An insurer shall not in any way penalize, terminate, or refuse to compensate for covered services a physician or provider for discussing or communicating with a current, prospective, or former patient, or a party designated by a patient, pursuant to this section.

Revisor's Note

(1) Section 7(c)(1)(A), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to "including but not limited to." Throughout this chapter, the revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(2) Section 7(c)(1)(B), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "health care plan." For consistency throughout this chapter, the revised law substitutes the defined term "health insurance policy" for "health care plan."

Revised Law

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) An insurer may not use any financial incentive or make payment to a physician or health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment. (V.T.I.C. Art. 3.70-3C, Sec. 7(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (d) An insurer shall not use any financial incentive or make payment to a physician or health care provider which acts directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the use of capitation as a method of payment.

[Sections 1301.069-1301.100 reserved for expansion]

SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

Revised Law

Sec. 1301.101. DEFINITION. In this subchapter, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 3A. (a) In this section, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy.

Revised Law

Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A preferred provider may obtain acknowledgment of receipt of a claim for medical care or health care services under a health insurance policy by submitting the claim by United States mail, return receipt requested.

(b) An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge receipt of

the claim by an electronic transmission to the preferred provider and is not required to acknowledge receipt of the claim in writing. (V.T.I.C. Art. 3.70-3C, Sec. 3A(b), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (b) A preferred provider for medical care or health care services under a health insurance policy may obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim by United States mail, return receipt requested. An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the preferred provider and is not required to acknowledge receipt of the claim by the insurer in writing.

Revisor's Note

(1) Section 3A(b), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "preferred provider for medical care or health care services under a health insurance policy." The revised law omits "for medical care or health care services under a health insurance policy" as unnecessary because those concepts are included in the definition of "preferred provider" under Section 1(10), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.001(8).

(2) Section 3A(b), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "health care plan." The revised law substitutes "health insurance policy" for "health care plan" for the reason stated in Revisor's Note (2) to Section 1301.067.

Revised Law

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not later than the 45th day after the date on which an insurer receives a clean claim from a preferred provider, the insurer shall:

(1) pay the total amount of the claim in accordance

with the contract between the preferred provider and the insurer;

(2) pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) notify the preferred provider in writing why the claim will not be paid. (V.T.I.C. Art. 3.70-3C, Sec. 3A(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (c) Not later than the 45th day after the date that the insurer receives a clean claim from a preferred provider, the insurer shall:
>
> (1) pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;
>
> (2) pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or
>
> (3) notify the preferred provider in writing why the claim will not be paid.

Revised Law

Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION BENEFIT CLAIMS. If a preferred provider or its designated agent authorizes treatment, a prescription benefit claim that is electronically adjudicated and electronically paid shall be paid not later than the 21st day after the date on which the treatment is authorized. (V.T.I.C. Art. 3.70-3C, Sec. 3A(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (d) If a prescription benefit claim is electronically adjudicated and electronically paid, and the preferred provider or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized.

Revised Law

Sec. 1301.105. AUDITED CLAIMS. An insurer that acknowledges coverage of an insured under a health insurance policy but intends to audit a claim submitted by a preferred provider shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date on which the insurer receives the claim from the preferred provider. Following

completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:

(1) the preferred provider receives notice of the audit results; or

(2) any appeal rights of the insured are exhausted. (V.T.I.C. Art. 3.70-3C, Sec. 3A(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (e) If the insurer acknowledges coverage of an insured under the health insurance policy but intends to audit the preferred provider claim, the insurer shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the insurer receives the claim from the preferred provider. Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:
>
> (1) the preferred provider receives notice of the audit results; or
>
> (2) any appeal rights of the insured are exhausted.

Revised Law

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES. (a) An insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(b) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with a claim.

(c) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 3A(i), (j), (k), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(i) The insurer shall provide a preferred

provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(j) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with the preferred provider claim.

(k) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider.

Revised Law

Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS; ADMINISTRATIVE PENALTY. (a) An insurer that violates Section 1301.103 or 1301.105 is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health insurance policy.

(b) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Section 1301.103 or 1301.105 is subject to an administrative penalty under Chapter 84. The administrative penalty imposed under that chapter may not exceed $1,000 for each day the claim remains unpaid in violation of Section 1301.103 or 1301.105. (V.T.I.C. Art. 3.70-3C, Secs. 3A(f), (h), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(f) An insurer that violates Subsection (c) or (e) of this section is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health insurance policy.

(h) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Subsection (c) or (e) of this section is subject to an administrative penalty under Article 1.10E of this code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of Subsection (c) or (e) of this section.

Revised Law

Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may

recover reasonable attorney's fees in an action to recover payment under this subchapter. (V.T.I.C. Art. 3.70-3C, Sec. 3A(g), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(g) A preferred provider may recover reasonable attorney's fees in an action to recover payment under this section.

Revised Law

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person with whom an insurer contracts to:

(1) process claims; or

(2) obtain the services of a preferred provider to provide medical care or health care to an insured under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(m), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(m) This section applies to a person with whom an insurer contracts to process claims or to obtain the services of preferred providers to provide medical care or health care to insureds under a health insurance policy.

Revised Law

Sec. 1301.110. EXCEPTION. This subchapter does not apply to a claim submitted by a preferred provider who is a member of the legislature. (V.T.I.C. Art. 3.70-3C, Sec. 3A(l), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(l) This section does not apply to a claim made by a preferred provider who is a member of the legislature.

Revisor's Note
(End of Subchapter)

Section 3A(n), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, authorizes the commissioner of insurance to adopt rules as necessary to implement Section 3A, Article 3.70-3C, revised as this

subchapter. The revised law omits this provision as unnecessary because Section 9, Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.007, requires the commissioner of insurance to adopt rules to implement Article 3.70-3C, including Section 3A. The omitted law reads:

> (n) The commissioner of insurance may adopt rules as necessary to implement this section.

[Sections 1301.111-1301.150 reserved for expansion]

SUBCHAPTER D. RELATIONS BETWEEN INSUREDS AND PREFERRED PROVIDERS

Revised Law

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured is entitled to treatment and diagnostic techniques that are prescribed by the physician or health care provider included in the preferred provider benefit plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (e) Each insured patient shall have the right to treatment and diagnostic techniques as prescribed by the physician or other health care provider included in the preferred provider benefit plan.

Revisor's Note

Section 3(e), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to an "insured patient." The revised law substitutes "insured" for "insured patient" for consistency throughout this chapter.

Revised Law

Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An insurer shall establish reasonable procedures for ensuring a transition of insureds to physicians or health care providers and for continuity of treatment.

(b) An insurer shall:

(1) provide, subject to Section 1301.160, reasonable advance notice to an insured of the impending termination of the participation in the plan of a physician or health care provider who is currently treating the insured; and

(2) in the event of termination of a preferred provider's participation in the plan, make available to the insured a current listing of preferred providers.

(c) A contract between an insurer and a physician or health care provider must include a procedure for resolving disputes regarding the necessity for continued treatment by the physician or provider. (V.T.I.C. Art. 3.70-3C, Secs. 4(a), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 4. (a) The insurer shall establish reasonable procedures for assuring a transition of insureds to physicians or health care providers and for continuity of treatment. Insurers shall provide, subject to Section 6(e) of this article, reasonable advance notice to the insured of the impending termination from the plan of a physician or health care provider who is currently treating the insured and in the event of termination of a preferred provider's participation in the plan shall make available to the insured a current listing of preferred providers.
>
> (d) Contracts between an insurer, physicians, and health care providers shall include procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

Revised Law

Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

(1) "Life-threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(2) "Special circumstances" means a condition regarding which the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the insured. Examples of an insured who has a special circumstance include an insured with a disability, acute condition, or life-threatening illness or an insured who is past the 24th week of pregnancy.

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, does not:

(1) release the physician or health care provider from the generally recognized obligation to:

(A) treat an insured whom the physician or provider is currently treating; and

(B) cooperate in arranging for appropriate referrals; or

(2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

(c) The treating physician or health care provider shall identify a special circumstance. The treating physician or health care provider shall:

(1) request that the insured be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the insured of any amount for which the insured would not be responsible if the physician or provider were still a preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 1(7), 4(b), (c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

[Sec. 1]

(7) "Life threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

[Sec. 4]

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of a preferred provider's participation in the plan, except for reason of

medical competence or professional behavior, shall not release the physician or health care provider from the generally recognized obligation to treat the insured and to cooperate in arranging for appropriate referrals; nor does it release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured at the same preferred provider rate if, at the time of the preferred provider's termination, the insured has special circumstances such as a disability, acute condition, or life-threatening illness or is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.

(c) For purposes of Subsection (b) of this section, "special circumstances" means a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient. Special circumstances shall be identified by the treating physician or health care provider, who must request that the insured be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the insured would not be responsible if the physician or provider were still a preferred provider.

Revised Law

Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF INSURER. (a) Except as provided by Subsection (b), Sections 1301.152 and 1301.153 do not extend an insurer's obligation to reimburse the terminated physician or provider or, if applicable, the insured at the preferred provider level of coverage for ongoing treatment of an insured after:

(1) the 90th day after the effective date of the termination; or

(2) if the insured has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination.

(b) If an insured is past the 24th week of pregnancy at the time of termination, an insurer's obligation to reimburse, at the preferred provider level of coverage, the physician or provider or, if applicable, the insured, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery. (V.T.I.C. Art. 3.70-3C, Sec. 4(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(e) This section does not extend the obligation

of the insurer to reimburse, at the preferred provider level of coverage, the terminated physician or health care provider or, if applicable, the insured for ongoing treatment of an insured after the 90th day from the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the insurer to reimburse, at the preferred provider level of coverage, the terminated physician or health care provider or, if applicable, the insured who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate post-partum care, and the follow-up checkup within the first six weeks of delivery.

Revised Law

Sec. 1301.155. EMERGENCY CARE. (a) In this section, "emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(1) placing the person's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of a bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and

(3) services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition. (V.T.I.C. Art. 3.70-3C, Secs. 1(1), 5, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 1. In this article:

(1) "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Sec. 5. If the insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital which is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services including the treatment and stabilization of an emergency medical condition; and

(3) services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition.

Revised Law

Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer shall comply with Subchapter B, Chapter 542, with respect to prompt payment to insureds. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(m) An insurer shall comply with Article 21.55 of this code with respect to prompt payment of insureds. . . .

Revised Law

Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health

insurance policy, health benefit plan certificate, endorsement, amendment, application, or rider must:

(1) be written in plain language;

(2) be in a readable and understandable format; and

(3) comply with all applicable requirements relating to minimum readability requirements. (V.T.I.C. Art. 3.70-3C, Sec. 6(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 6. (a) All health insurance policies, health benefit plan certificates, endorsements, amendments, applications, or riders shall be written in plain language, must be in a readable and understandable format, and must comply with all applicable requirements relating to minimum readability requirements.

Revised Law

Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" means:

(1) for group coverage, an individual or an individual's dependent who is eligible for coverage under a health insurance policy issued to the group; or

(2) for individual coverage, an individual or an individual's dependent who is eligible for coverage and who has expressed an interest in purchasing an individual health insurance policy.

(b) An insurer shall provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms of the health insurance policy to allow the current or prospective group contract holder or current or prospective insured to make comparisons and an informed decision before selecting among health care plans. The description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may satisfy this requirement by providing its handbook if:

(1) the handbook's content is substantively similar to and achieves the same level of disclosure as the written

description prescribed by the commissioner; and

(2) the current list of preferred providers is provided.

(c) An insurer or an agent or representative of an insurer may not use or distribute, or permit the use or distribution of, information for prospective insureds that is untrue or misleading. (V.T.I.C. Art. 3.70-3C, Secs. 1(11), 6(b), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

[Sec. 1]

(11) "Prospective insured" means:

(A) for group coverage, an individual, including dependents, eligible for coverage under a health insurance policy issued to the group; or

(B) for individual coverage, an individual, including dependents, eligible for coverage who has expressed an interest in purchasing an individual health insurance policy.

[Sec. 6]

(b) The insurer shall provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms and conditions of the policy to allow the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. The written description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may provide its handbook to satisfy this requirement provided the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner and the current list of physicians and health care providers is provided.

(d) No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of prospective insured information which is untrue or misleading.

Revised Law

Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A current list of preferred providers shall be provided to each insured at least annually. (V.T.I.C. Art. 3.70-3C, Sec. 6(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(c) A current list of preferred providers shall be provided to all insureds no less than annually.

Revised Law

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal recommendation regarding the termination.

(b) A physician or health care provider that voluntarily terminates the physician's or provider's participation in a preferred provider benefit plan shall provide reasonable notice to each insured under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in ensuring that the notice requirements of this subsection are met.

(c) If a practitioner's participation in a preferred provider benefit plan is terminated for reasons related to imminent harm, an insurer may notify insureds immediately. (V.T.I.C. Art. 3.70-3C, Sec. 6(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(e)(1) If a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer shall not notify enrollees of the termination until the effective date of the termination or at such time as a review panel makes a formal recommendation regarding the termination, whichever is later.

(2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, the physician or provider shall provide reasonable notice to enrollees under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in assuring that the notice requirements of this subdivision are met.

(3) If a physician or practitioner is terminated for reasons related to imminent harm, an insurer may notify enrollees immediately.

Revisor's Note

Section 6(e), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to an "enrollee" under a

preferred provider benefit plan. For consistency throughout this chapter, the revised law substitutes "insured" for "enrollee."

Revised Law

Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An insurer may not engage in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has:

(1) filed a complaint against the insurer or against a preferred provider; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 7. (a) No insurer shall engage in any retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured, or a person acting on behalf of the insured, has filed a complaint against the insurer or against a preferred provider or has appealed a decision of the insurer.

[Sections 1301.162-1301.200 reserved for expansion]

SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

Revised Law

Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE FIRST ASSISTANTS. A preferred provider may not refuse to:

(1) contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network; or

(2) reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform. (V.T.I.C. Art. 3.70-3C, Sec. 3(o), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> (o) A preferred provider may not refuse to contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician

has requested the nurse first assistant to perform.

[Chapters 1302-1350 reserved for expansion]

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

CHAPTER 1351. HOME HEALTH SERVICES

Revised Law

Sec. 1351.001. DEFINITIONS. In this chapter:

(1) "Health services" includes:

(A) skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;

(B) physical, occupational, speech, or respiratory therapy;

(C) the services of a home health aide under the supervision of a registered nurse; and

(D) the furnishing of medical equipment and supplies other than drugs or medicines.

(2) "Home health agency" means a business that:

(A) provides home health services; and

(B) is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

(3) "Home health services" means the provision of health services for payment or other consideration in a patient's residence under a plan of care that is:

(A) established, approved in writing, and reviewed at least every two months by the attending physician; and

(B) certified by the attending physician as necessary for medical purposes. (V.T.I.C. Art. 3.70-3B, Sec. 1.)

Source Law

Art. 3.70-3B
Sec. 1. As used in this article:
(1) "Health services" includes:
(A) skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;
(B) physical, occupational, speech, or respiratory therapy;
(C) the service of a home health aide under the supervision of a registered nurse; and
(D) the furnishing of medical equipment and medical supplies other than drugs and medicines.
(2) "Home health agency" means a business that provides home health service and is licensed by the Texas Department of Health under Chapter 142, Health and Safety Code.
(3) "Home health service" means the provision of a health service for payment or other consideration in a patient's residence under a plan of care established, approved in writing, and reviewed at least every two months by the attending physician and certified by the attending physician as necessary for medical purposes.

Revisor's Note

Section 1, V.T.I.C. Article 3.70-3B, refers to a home health agency that is "licensed by the Texas Department of Health under Chapter 142, Health and Safety Code." Under Section 1.24, Chapter 1505, Acts of the 76th Legislature, Regular Session, 1999, responsibility for licensing agencies under Chapter 142 was transferred from the Texas Department of Health to the Texas Department of Human Services. The revised law is drafted accordingly.

Revised Law

Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a group health benefit plan that is delivered or

issued for delivery in this state and that is a group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842.

(b) This chapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part); Art. 3.70-8, Secs. (a) (part), (b).)

Source Law

[Art. 3.70-3B]

Sec. 2. (a) . . . a group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20 of this code, may not be delivered or issued for delivery to any person in this state [unless benefits for home health service provided by a licensed home health agency are included in that group policy.] . . .

Art. 3.70-8. [(a) Nothing in this Act shall apply to . . . any blanket or group policy of insurance except as provided] . . . in article 3.70-3B . . . .

(b) This Act applies to a health, accident, sickness, and hospitalization policy issued by a stipulated premium insurer subject to Chapter 884 of this code.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 3.70-3B, refers to a group policy of "accident and sickness insurance." Similarly, Sections (a) and (b), V.T.I.C. Article 3.70-8, refer to a "blanket or group policy of insurance," meaning a policy of accident and sickness insurance described by Section (B), V.T.I.C. Article 3.70-2, and to a "health, accident, sickness, and hospitalization policy," respectively. For consistency with modern usage, the revised law substitutes "accident and health" for "accident and sickness" and for "health, accident, sickness, and hospitalization." Comparable changes necessary to ensure consistent use of terminology have been made throughout this chapter.

(2) Section 2(a), V.T.I.C. Article 3.70-3B, refers to "policies issued by companies" subject to

V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a company is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "companies" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to V.T.I.C. Article 3.70-3B, revised as this chapter. It is clear that the legislature intended the general provisions of Chapter 397 to apply to Article 3.70-3B because when the legislature enacted Article 3.70-3B, it also amended V.T.I.C. Article 3.70-8, a nonapplicability provision derived from Chapter 397, to provide an exception for Article 3.70-3B. The majority of the articles derived from Chapter 397 are revised in this code as Chapter 1201. Section 1351.003 is added to indicate the applicability of the general provisions of those articles to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1351.004. EXCEPTION. This chapter does not apply to:

(1) a group policy of accident and health insurance that provides coverage only for:

(A) a specified disease or diseases;

(B) vision care;

(C) dental care;

(D) hospital indemnity;

(E) prescription drugs; or

(F) other limited benefits;

(2) a blanket insurance policy, as described by Chapter 1251;

(3) a short-term travel insurance policy;

(4) an accident-only insurance policy;

(5) a hospital indemnity insurance policy;

(6) a limited or specified disease insurance policy;

(7) an insurance policy or contract issued under a right of conversion; or

(8) an insurance policy or contract designed for issuance to a person eligible for Medicare coverage. (V.T.I.C. Art. 3.70-3B, Sec. 2(c).)

Source Law

(c) This article does not apply to:

(1) group accident and sickness policies that provide only coverage for a specified disease or diseases, vision care, dental care, hospital indemnity, prescription drugs, or other limited benefits;

(2) blanket insurance policies, as defined in Article 3.51-6, Insurance Code;

(3) short-term travel insurance;

(4) accident-only insurance;

(5) hospital indemnity policies;

(6) limited or specified disease policies;

(7) insurance policies or contracts issued pursuant to a right of conversion; or

(8) insurance policies or contracts designed for issuance to persons eligible for Medicare.

Revised Law

Sec. 1351.005. COVERAGE REQUIRED. Except as provided by Section 1351.008, a group health benefit plan must provide coverage

for home health services provided by a home health agency. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Source Law

> Sec. 2. (a) Except as provided by Subsections (b) and (c) of this section, [a group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20 of this code, may not be delivered or issued for delivery to any person in this state] unless benefits for home health service provided by a licensed home health agency are included in that group policy. . . .

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 3.70-3B, prohibits the delivery or issuance of certain group policies "[e]xcept as provided by Subsections . . . (c) of this section." Section 2(c), V.T.I.C. Article 3.70-3B, revised as Section 1351.004, specifies the types of coverage exempt from the application of V.T.I.C. Article 3.70-3B, revised as this chapter. The revised law omits "[e]xcept as provided by Subsections . . . (c) of this section" as unnecessary because if a policy is exempt under Section 2(c), then the policy is not subject to the prohibition stated in Section 2(a).

(2) Section 2(a), V.T.I.C. Article 3.70-3B, refers to a "licensed home health agency." The revised law omits "licensed" as unnecessary because "home health agency" is defined by Section 1(2) of that article, revised as Section 1351.001(2), to mean a business that is licensed by the Texas Department of Human Services.

Revised Law

Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES: PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan issuer may not provide reimbursement for home health services provided under the plan unless the attending physician certifies that hospitalization or confinement in a skilled facility would be

required if a treatment plan for home health care were not provided. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Source Law

> (a) . . . Home health services provided under this section may not be reimbursed unless the attending physician certifies that hospitalization or confinement in a skilled facility would otherwise be required if a treatment plan for home health care was not provided.

Revised Law

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE PERMITTED. (a) A group health benefit plan may include:

(1) a limitation on the number of visits for home health services for which benefits are payable, subject to Subsection (b);

(2) an exclusion for home health services coverage for:

(A) custodial care;

(B) services provided by an individual who:

(i) resides in the covered individual's home; or

(ii) is a member of the covered individual's family; or

(C) services provided to a covered individual who is eligible for Medicare coverage;

(3) annual deductible and coinsurance provisions for home health services coverage that are not less favorable than the deductible or coinsurance provisions applicable to hospital services coverage under the plan; and

(4) other coverage limitations or exclusions consistent with the remaining provisions of the plan.

(b) A limitation under Subsection (a)(1) may not limit each individual covered under the plan to fewer than 60 visits in any calendar year or continuous 12-month period.

(c) For purposes of this section, each of the following is considered to be one visit for home health services:

(1) a visit by a representative of a home health agency;

(2) four hours of home health aide service; and

(3) if home health aide service extends beyond four hours, each additional four hours or portion of that four-hour period. (V.T.I.C. Art. 3.70-3B, Secs. 3(a), (b), (c).)

Source Law

> Sec. 3. (a) A policy of accident or sickness insurance issued under Subsection (a) of Section 2 of this article may include:
>
> (1) a limitation on the number of home health care visits for which benefits are payable, provided the number of visits for which benefits are payable may not be fewer than 60 visits in any calendar year or in any continuous period of 12 months for each person covered under the policy or contract;
>
> (2) annual deductible and coinsurance provisions provided that those provisions are not less favorable than the deductible or coinsurance provisions applicable to covered hospital services under the policy; and
>
> (3) an exclusion for home health benefits for custodial care, for services provided by a person who resides in the covered person's home or is a member of the covered person's family, or for services provided to a covered person who is eligible for Medicare.
>
> (b) For the purposes of Subdivision (1) of Subsection (a) of this section, each visit by a representative of a home health agency is considered as one home health care visit, four hours of home health aide service is considered as one home health care visit, and if service extends beyond four hours, each four hours or portion of that period is considered as one home health care visit.
>
> (c) Home health benefits may be subject to limitations and exclusions consistent with the balance of the policy or contract.

Revised Law

Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER; NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group health benefit plan rejects in writing the coverage required under this chapter, the plan issuer:

(1) may not include the coverage in the plan; and

(2) is not required to:

(A) offer the coverage to the plan holder; or

(B) provide the coverage under the plan.

(b) If a plan holder rejects in writing the coverage required under this chapter, the plan holder and the plan issuer may

negotiate coverage for home health services other than the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 2(b).)

Source Law

> (b) An insurer may not include the coverage required by Subsection (a) of this section if the policyholder rejects the coverage in writing. If a policyholder rejects the coverage in writing as provided by this subsection, the insurer has no further obligation to offer or to provide coverage for services under this article, provided that nothing contained herein shall prevent the policyholder and insurer from negotiating other benefits for home health services following policyholder rejection as provided above.

Revised Law

Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This chapter does not preclude a group health benefit plan issuer from providing coverage for home health services that exceeds the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 3(d).)

Source Law

> (d) This article does not preclude a group policy of accident and sickness insurance, including policies issued by companies licensed pursuant to Chapter 20 of this code, from including home health services in excess of those provided in this article.

CHAPTER 1352. BRAIN INJURY

CHAPTER 1352. BRAIN INJURY

Revised Law

Sec. 1352.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is

offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a Lloyd's plan operating under Chapter 941;

(7) a health maintenance organization operating under Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53Q, Secs. 1(a), (b).)

Source Law

Art. 21.53Q

Sec. 1. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a Lloyd's plan operating under Chapter 18 of this code;

(7) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(8) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) This article applies to a small employer health benefit plan written under Chapter 26 of this code.

Revised Law

Sec. 1352.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1352.001. (V.T.I.C. Art. 21.53Q, Sec. 1(c).)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for benefits for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this chapter may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits applicable to other similar coverage provided under the health benefit plan.

(c) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.53Q, Sec. 2.)

Source Law

Sec. 2. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this article may be

subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with deductibles, copayments, coinsurance, and annual or maximum payment limits applicable to other similar coverage under the plan.

(c) The commissioner shall adopt rules as necessary to implement this section.

Revised Law

Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services if the physician or provider provides those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider.

(b) The commissioner by rule shall require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage in violation of Section 1352.003 and to avoid confusion of medical benefits with mental health benefits. (V.T.I.C. Art. 21.53Q, Sec. 3.)

Source Law

Sec. 3. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether the issuer of a health benefit plan will pay the physician or provider for proposed medical or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer of a health benefit plan to a physician or health care provider.

(b) The commissioner by rule shall require the issuer of a health benefit plan to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan to prevent wrongful denial of coverage required under this article and to avoid confusion of medical benefits with mental health benefits.

CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER MANAGED CARE PLANS

CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER MANAGED CARE PLANS

Revised Law

Sec. 1353.001. PROHIBITED CONDUCT. A managed care entity may not:

(1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan;

(2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued;

(3) provide a financial incentive to a physician to issue an immunization or vaccination protocol; or

(4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol. (V.T.I.C. Art. 21.53K, Sec. 1.)

Source Law

Art. 21.53K

Sec. 1. (a) A managed care entity may not require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan.

(b) This section prohibits a managed care entity from:

(1) limiting benefits to enrollees for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued;

(2) providing financial incentives to physicians to issue an immunization or vaccination protocol; or

(3) imposing a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol.

Revised Law

Sec. 1353.002. RULES. The commissioner may adopt rules to

implement this chapter. (V.T.I.C. Art. 21.53K, Sec. 2.)

Source Law

Sec. 2. The commissioner may adopt rules to implement this article.

CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

Revised Law

Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides coverage for Alzheimer's disease; and

(2) is an individual or group policy, contract, certificate, or evidence of coverage that is delivered or issued for delivery in this state by an insurer or a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.78 (part).)

Source Law

Art. 3.78. [If] an individual or group policy, contract, or certificate, or evidence of coverage providing coverage for Alzheimer's disease is delivered or issued for delivery in this state by an insurer, including a group hospital service corporation under Chapter 20 of this code, and . . . .

Revised Law

Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies. (V.T.I.C. Art. 3.78 (part).)

Source Law

Art. 3.78. If [an individual or group policy,

contract, or certificate, or evidence of coverage providing coverage for Alzheimer's disease is delivered or issued for delivery in this state by an insurer, including a group hospital service corporation under Chapter 20 of this code, and] the policy, contract, certificate, or evidence requires demonstrable proof of organic disease or other proof before the insurer will authorize payment of benefits for Alzheimer's disease, a clinical diagnosis of Alzheimer's disease by a physician licensed in this state, including history and physical, neurological, psychological and/or psychiatric evaluations, and laboratory studies, shall satisfy the requirement for demonstrable proof of organic disease or other proof under the coverage.

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN

COVERAGE FOR CERTAIN SERIOUS MENTAL ILLNESSES

[Sections 1355.008-1355.050 reserved for expansion]

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN SERIOUS MENTAL ILLNESSES

Revised Law

Sec. 1355.001. DEFINITIONS. In this subchapter:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric

Association in the Diagnostic and Statistical Manual (DSM):

(A) bipolar disorders (hypomanic, manic, depressive, and mixed);

(B) depression in childhood and adolescence;

(C) major depressive disorders (single episode or recurrent);

(D) obsessive-compulsive disorders;

(E) paranoid and other psychotic disorders;

(F) pervasive developmental disorders;

(G) schizo-affective disorders (bipolar or depressive); and

(H) schizophrenia.

(2) "Small employer" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 3.51-14, Secs. 1(1), (3).)

Source Law

Art. 3.51-14

Sec. 1. For purposes of this article:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizo-affective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders; and

(H) depression in childhood and adolescence.

(3) "Small employer" has the meaning assigned by Article 26.02 of this code.

Revisor's Note

Section 1(2), V.T.I.C. Article 3.51-14, defines "group health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1355.002 and 1355.003, specifies the types of group health benefit plans to

which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (2) "Group health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement. (V.T.I.C. Art. 3.51-14, Sec. 2(a).)

Source Law

> Sec. 2. (a) This article applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:
> (1) a group insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(A) an insurance company;
(B) a group hospital service corporation operating under Chapter 20 of this code;
(C) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
(D) a fraternal benefit society operating under Chapter 10 of this code; or
(E) a stipulated premium insurance company operating under Chapter 22 of this code; and
(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a group health benefit plan that is offered under:
(A) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or
(B) another analogous benefit arrangement.

Revised Law

Sec. 1355.003. EXCEPTION. (a) This subchapter does not apply to coverage under:

(1) a blanket accident and health insurance policy, as described by Chapter 1251;

(2) a short-term travel policy;

(3) an accident-only policy;

(4) a limited or specified-disease policy that does not provide benefits for mental health care or similar services;

(5) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;

(6) a plan offered in accordance with Section 1355.151; or

(7) a Medicare supplement benefit plan, as defined by Section 1652.002.

(b) For the purposes of a plan described by Subsection (a)(5), "serious mental illness" has the meaning assigned by Section 1355.001. (V.T.I.C. Art. 3.51-14, Sec. 2(b).)

Source Law

(b) This article does not apply to coverage under:
(1) a blanket accident and health insurance policy as that term is defined under Section 2, Article 3.51-6, of this code;
(2) a short-term travel policy;
(3) an accident-only policy;
(4) a limited or specified-disease policy,

other than a plan that provides benefits for mental health care or similar services;

(5) with the exception of Section 1 of this article which shall apply, a plan offered under the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code) or the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code);

(6) a plan offered under or in accordance with Article 3.51-5A of this code; or

(7) a Medicare supplement policy, as that term is defined under Section 1(b)(3), Article 3.74, of this code.

Revisor's Note

(1) Section 2(b)(5), V.T.I.C. Article 3.51-14, provides that "Section 1 of this article . . . shall apply" to a plan offered under V.T.I.C. Article 3.50-2 or 3.50-3, revised as Chapters 1551 and 1601 of this code. The clear purpose of the quoted language is to preserve the definition of "serious mental illness" for the purposes of those plans. The term "small employer" is not used in Chapter 1551 or 1601, and the definition of "group health benefit plan" is not applicable in those chapters. The revised law is drafted accordingly.

(2) Section 2(b)(7), V.T.I.C. Article 3.51-14, refers to "a Medicare supplement policy, as that term is defined under Section 1(b)(3), Article 3.74, of this code." The revised law substitutes "Medicare supplement benefit plan" because that is the term used in Section 1652.002, which revises Section 1(b)(3), V.T.I.C. Article 3.74.

Revised Law

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS. (a) A group health benefit plan:

(1) must provide coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year:

(A) 45 days of inpatient treatment; and

(B) 60 visits for outpatient treatment,

including group and individual outpatient treatment;

(2) may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment covered under the plan; and

(3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness.

(b) A group health benefit plan issuer:

(1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (a)(1)(B); and

(2) must provide coverage for an outpatient visit described by Subsection (a)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness. (V.T.I.C. Art. 3.51-14, Secs. 3(a), (b).)

Source Law

> Sec. 3. (a) Except as provided by Section 4 of this article, a group health benefit plan:
>
> (1) must provide coverage, based on medical necessity, for the following treatment of serious mental illness in each calendar year:
>
> (A) 45 days of inpatient treatment; and
>
> (B) 60 visits for outpatient treatment, including group and individual outpatient treatment;
>
> (2) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and
>
> (3) must include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.
>
> (b) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under Subsection (a)(1) of this section an outpatient visit for the purpose of medication management and must cover that outpatient visit under the same terms and conditions as it covers outpatient visits for treatment of physical illness.

Revised Law

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan. (V.T.I.C. Art. 3.51-14, Sec. 3(c).)

Source Law

(c) An issuer of a group health benefit plan may provide or offer coverage required under this section through a managed care plan.

Revised Law

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law. (V.T.I.C. Art. 3.51-14, Sec. 5.)

Source Law

Sec. 5. (a) This article may not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness resulting from the use of a controlled substance or marihuana in violation of law.

(b) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

Revised Law

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage. (V.T.I.C. Art. 3.51-14, Sec. 4.)

Source Law

Sec. 4. An issuer of a group health benefit plan to a small employer must offer the coverage described in Section 3 of this article but is not required to provide the coverage if the small employer rejects the coverage.

[Sections 1355.008-1355.050 reserved for expansion]

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

Revised Law

Sec. 1355.051. DEFINITIONS. In this subchapter:

(1) "Crisis stabilization unit" means a 24-hour residential program that provides, usually for a short term, intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

(2) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives that are appropriate to:

(A) the patient; and

(B) the program's treatment modality.

(3) "Residential treatment center for children and adolescents" means a child-care institution that:

(A) is accredited as a residential treatment center by:

(i) the Council on Accreditation;

(ii) the Joint Commission on Accreditation of Healthcare Organizations; or

(iii) the American Association of Psychiatric Services for Children; and

(B) provides residential care and treatment for emotionally disturbed children and adolescents. (V.T.I.C. Art. 3.72, Subsec. (a).)

Source Law

Art. 3.72. (a) In this article:

(1) "Crisis stabilization unit" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

(2) "Residential treatment center for children and adolescents" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for

Children.

(3) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Revisor's Note

Subsection (a)(2), V.T.I.C. Article 3.72, refers to the "Joint Commission on Accreditation of Hospitals." Throughout this chapter, the revised law substitutes a reference to the "Joint Commission on Accreditation of Healthcare Organizations" for the quoted language because that is the proper name of the organization to which that language refers.

Revised Law

Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is:

(1) an accident and health insurance group policy;

(2) a group policy issued by a group hospital service corporation operating under Chapter 842; or

(3) a group health care plan provided by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

Source Law

(b) . . . a group policy of accident and sickness insurance delivered or issued for delivery to a person in this state, including a group policy issued by a group hospital service plan subject to Chapter 20 of this code and a group health care plan provided by a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), ...

Revisor's Note

(1) Subsection (b), V.T.I.C. Article 3.72, refers to a "group hospital service plan subject to Chapter 20 of this code," meaning a corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law

substitutes "group hospital service corporation" for "group hospital service plan" to provide consistent use of terminology in this code.

(2) Subsection (b), V.T.I.C. Article 3.72, describes a "group policy of accident and sickness insurance." The revised law substitutes "group health benefit plan" for "group policy of accident and sickness insurance" because the term, as described, includes coverage provided by a health maintenance organization that is not insurance. Consequently, "group health benefit plan" is a more accurate term. The substitution of this term and related changes necessary to ensure consistent terminology are made throughout this subchapter.

Revised Law

Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND DISORDERS. A group health benefit plan that provides coverage for treatment of mental or emotional illness or disorder for a covered individual when the individual is confined in a hospital must also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a hospital. (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

Source Law

(b) Subject to the conditions of this article, a . . . plan . . . that provides coverage for treatment of mental or emotional illness or disorder for an insured when confined in a hospital must also include coverage that is not less favorable for treatment in a residential treatment center for children and adolescents or from a crisis stabilization unit.

Revised Law

Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of coverage provided under this subchapter may be used only in a situation in which:

(1) the covered individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

(b) The service for which benefits are to be paid from coverage provided under this subchapter must be:

(1) based on an individual treatment plan for the covered individual; and

(2) provided by a service provider licensed or operated by the appropriate state agency to provide those services.

(c) Benefits under coverage provided under this subchapter are subject to the same benefit maximums, durational limitations, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment under the coverage. (V.T.I.C. Art. 3.72, Subsec. (c).)

Source Law

(c) Coverage provided under this article is subject to the following conditions:

(1) the benefits provided by this article may be used only in situations in which the insured has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and treatment were not available through a crisis stabilization unit or residential treatment center for children and adolescents;

(2) the services rendered for which benefits are to be paid must be based on an individual treatment plan;

(3) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services; and

(4) the benefits are subject to the same benefit maximums, durational limits, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment.

Revisor's Note

Subsection (c)(3), V.T.I.C. Article 3.72, refers to the "appropriate state agency or board." The revised law omits the reference to a state board as unnecessary because a state board is included in the meaning of "state agency."

Revised Law

Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS. (a) Treatment in a residential treatment center for children and adolescents must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining policy benefits and benefit maximums, each two days of treatment in a residential treatment center for children and adolescents is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. (V.T.I.C. Art. 3.72, Subsec. (d).)

Source Law

(d) Treatment in a residential treatment center for children and adolescents shall be determined as if necessary care and treatment in a residential treatment center for children and adolescents were inpatient care and treatment in a hospital, and each two days of treatment in a residential treatment center for children and adolescents will be considered equal to one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program for the purpose of determining policy benefits and benefit maximums.

Revised Law

Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining plan benefits and benefit maximums, each two days of treatment in a crisis stabilization unit is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

(c) Treatment provided to an individual by a crisis stabilization unit licensed or certified by the Texas Department of Mental Health and Mental Retardation shall be reimbursed. (V.T.I.C. Art. 3.72, Subsec. (e).)

Source Law

> (e) Treatment provided through crisis stabilization units shall be determined as if necessary care and treatment through crisis stabilization units were inpatient care and treatment in a hospital, and two days in a crisis stabilization unit are considered equal to one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program for the purpose of determining policy benefits and benefit maximums. Treatment provided through crisis stabilization units shall be reimbursed for facilities licensed or certified by the Texas Department of Mental Health and Mental Retardation.

Revised Law

Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF REIMBURSEMENT. (a) The commissioner shall monitor and review the minimum ratios of reimbursement for alternative treatments required by Sections 1355.055 and 1355.056.

(b) If the commissioner finds that the limits provided by this subchapter are creating an artificial increase in the costs of services, the commissioner by rule may adjust the ratios to the extent necessary to prevent the artificial increase.

(c) Before the commissioner adjusts a ratio under Subsection (b), the commissioner must give notice and hold a hearing to:

(1) consider information related to the adjustment; and

(2) determine whether the information justifies the adjustment.

(d) The department shall review the reimbursement ratios at least every two years. (V.T.I.C. Art. 3.72, Subsec. (f) (part).)

Source Law

> (f) The State Board of Insurance shall monitor and review the minimum ratios of reimbursement required by Sections (d) and (e) of this article for alternative treatments, and if the board determines that the limits provided by this article are creating

an artificial rise in costs of services, the board by rule may adjust the ratios to the extent necessary to prevent this artificial rise in costs of services. Before the board adopts a rule adjusting a ratio of reimbursement, the board shall give notice and hold a hearing to consider the data relating to the adjustment and to determine if that data justifies the adjustment. . . . the board shall make subsequent reviews of the ratios of reimbursement at least every two years . . . .

Revisor's Note

(1) Subsection (f), V.T.I.C. Article 3.72, refers to "[t]he State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this subchapter, references to the board have been changed appropriately.

(2) Subsection (f), V.T.I.C. Article 3.72, provides that the State Board of Insurance (now Texas Department of Insurance) must make the first review of reimbursement ratios before January 1, 1990. The revised law omits the references to the initial review because that provision is executed. The omitted law reads:

> (f) . . . The first review by the board of ratios of reimbursement under this section must be made before January 1, 1990, and . . . [every two years] after the first review.

Revised Law

Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. (a) The Texas Department of Mental Health and Mental Retardation shall assist the department in carrying out the department's responsibilities under this subchapter.

(b) The department and the Texas Department of Mental Health and Mental Retardation by rule may adopt a memorandum of understanding to carry out this subchapter. (V.T.I.C. Art. 3.72, Subsec. (g).)

Source Law

(g) The Texas Department of Mental Health and Mental Retardation shall assist the board in carrying out its responsibilities under this article. To carry out this article, the State Board of Insurance and the Texas Department of Mental Health and Mental Retardation may by rule adopt memoranda of understanding.

[Sections 1355.059-1355.100 reserved for expansion]

SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

Revised Law

Sec. 1355.101. DEFINITION. In this subchapter, "psychiatric day treatment facility" means a mental health facility that:

(1) provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objectives that are appropriate to the patient and the program's treatment modality; and

(2) is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) . . . For the purpose of this subsection a psychiatric day treatment facility is a mental health facility which provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Revised Law

Sec. 1355.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group policy of accident and health insurance delivered or issued for delivery in this state, including a group policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) A group policy of accident and sickness insurance delivered or issued for delivery to a person in this state including a group policy issued by a company subject to Chapter 20 or . . . Texas Insurance Code, ...

Revisor's Note

(1) Section (F), V.T.I.C. Article 3.70-2, refers to a "group policy of accident and sickness insurance." For consistency with modern usage, the revised law substitutes "health" for "sickness."

(2) Section (F), V.T.I.C. Article 3.70-2, refers to a "company subject to Chapter 20," meaning a corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "company" to provide consistent use of terminology in this code. Similar changes are made throughout this subchapter.

Revised Law

Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (F), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11. The majority of these articles, which include general provisions applicable

to Section (F), V.T.I.C. Article 3.70-2, are revised as Chapter 1201 of this code. Section 1355.103 is added to indicate the applicability of those general provisions to this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

Revised Law

Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy that provides coverage for treatment of mental or emotional illness or disorder when an individual is confined in a hospital must also provide coverage for treatment obtained under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program.

(b) The psychiatric day treatment facility coverage required by this section may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors.

(c) A group insurance policy subject to this section may require that:

(1) the treatment obtained in a psychiatric day treatment facility be provided by a facility that treats a patient for not more than 8 hours in any 24-hour period;

(2) the attending physician certify that the treatment is in lieu of hospitalization; and

(3) the psychiatric day treatment facility be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Healthcare Organizations. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) A group policy . . . that provides coverage

for treatment of mental or emotional illness or disorder for a person when confined in a hospital must also provide that coverage, which is not less favorable, shall be applicable for treatment under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an in-patient program; subject to the same durational limits, deductibles, and coinsurance factors. . . . Any such policy may require that the treatment must be provided by a day treatment facility that treats a patient for not more than eight hours in any 24-hour period, that the attending physician certifies that such treatment is in lieu of hospitalization, and that the psychiatric treatment facility is accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. . . .

Revised Law

Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) Benefits provided under this subchapter shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital.

(b) For the purpose of determining policy benefits and benefit maximums, each full day of treatment in a psychiatric day treatment facility is the equivalent of one-half of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) . . . Any benefits so provided shall be determined as if necessary care and treatment in a psychiatric day treatment facility were in-patient care and treatment in a hospital, and each full day of treatment in a psychiatric day treatment facility shall be considered equal to one-half of one day of treatment of mental or emotional illness or disorder in a hospital or in-patient program for the purpose of determining policy benefits and benefit maximums. . . .

Revised Law

Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE BENEFITS. (a) An insurer shall offer, and a policyholder is entitled to reject, coverage under a group insurance policy for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility.

(b) A policyholder may select an alternative level of

benefits under the group insurance policy if the alternative level is offered by or negotiated with the insurer.

(c) The alternative level of benefits must provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed the usual and customary charges of the facility. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

> (F) . . . An insurer shall offer and the policyholder shall have the right to reject such coverage for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility or may select an alternative level of benefits thereunder if such coverage is offered by or negotiated with such insurer, service plan corporation or . . . provided, however, any such alternative level of benefits shall provide policy benefits and benefit maximums for treatment in psychiatric day treatment facilities equal to at least one half of that provided for treatment in hospital facilities, but not to exceed the usual and customary charge of the psychiatric day treatment facility. . . .

Revisor's Note

> Section (F), V.T.I.C. Article 3.70-2, refers to an "insurer" and to an "insurer [or] service plan corporation," meaning a group hospital service corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The portion of Section (F) that is revised as Section 1355.102 provides that Section (F), revised as this subchapter, applies to a group hospital service corporation. For consistency of terminology, the revised law uses the term "insurer" throughout this subchapter.

[Sections 1355.107-1355.150 reserved for expansion]

SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Revised Law

Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF CERTAIN COVERAGES. (a) In this section, "serious mental illness"

has the meaning assigned by Section 1355.001.

(b) A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that is less extensive for serious mental illness than the coverage provided for any other physical illness. (V.T.I.C. Art. 3.51-5A, Subsecs. (a) (part), (b).)

Source Law

> Art. 3.51-5A. (a) A municipality, county, school district, district created under Article III, Section 52, or Article XVI, Section 59, of the Texas Constitution, or other political subdivision of the state that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to its officers or employees or to both its officers and employees may not contract for or provide coverage that:
>
> . . .
>
> (2) is less extensive for serious mental illness than the coverage provided for any other physical illness.
>
> (b) For purposes of this article, "serious mental illness" has the meaning assigned by Section 1, Article 3.51-14, of this code.

Revisor's Note

Subsection (a), V.T.I.C. Article 3.51-5A, refers to "[a] municipality, county, school district, district created under Article III, Section 52, or Article XVI, Section 59, of the Texas Constitution, or other political subdivision of the state." The revised law substitutes the term "political subdivision" for the quoted language because each type of entity specified is included in the meaning of "political subdivision."

[Sections 1355.152-1355.200 reserved for expansion]

SUBCHAPTER E. BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION

Revised Law

Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions

relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (D), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, Vernon's Texas Insurance Code. The majority of these articles, which include general provisions applicable to Section (D), V.T.I.C. Article 3.70-2, are revised as Chapter 1201 of this code. Section 1355.201 is added to indicate the applicability of those general provisions to this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

Revised Law

Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION. (a) An individual or group accident and health insurance policy delivered or issued for delivery to a person in this state that provides coverage for mental illness or mental retardation may not exclude benefits under that coverage for support, maintenance, and treatment provided by a tax-supported institution of this state, or by a community center for mental health or mental retardation services, that regularly and customarily charges patients who are not indigent for those services.

(b) In determining whether a patient is not indigent, as provided by Subchapter B, Chapter 552, Health and Safety Code, a tax-supported institution of this state or a community center for

mental health or mental retardation services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or mental retardation. (V.T.I.C. Art. 3.70-2, Sec. (D).)

Source Law

> (D) No individual policy or group policy of accident and sickness insurance delivered or issued for delivery to any person in this state which provides coverage for mental illness or mental retardation or both mental illness and mental retardation shall exclude benefits for the support, maintenance and treatment of such mental illness or mental retardation provided by a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services, provided charges for the care or treatment of such mental illness or mental retardation are regularly and customarily charged to non-indigent patients by such tax supported institution. In determining whether or not a patient is a non-indigent patient, as provided in Chapter 152, Acts of the 45th Legislature, Regular Session, 1937 (Article 3196a, Vernon's Texas Civil Statutes), such tax supported institution shall consider any insurance policy (or policies) which provides coverage for mental illness or mental retardation or both mental illness and mental retardation to such patients.

Revisor's Note

Section (D), V.T.I.C. Article 3.70-2, refers to "Chapter 152, Acts of the 45th Legislature, Regular Session, 1937 (Article 3196a, Vernon's Texas Civil Statutes)." That statute was codified in 1991 as Subchapter B, Chapter 552, Health and Safety Code, and the revised law is drafted accordingly.

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

Revised Law

Sec. 1356.001. DEFINITION. In this chapter, "low-dose mammography" means the x-ray examination of the breast using

equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

> (H) In this section, "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. . . .

Revised Law

Sec. 1356.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that is delivered, issued for delivery, or renewed in this state and that is an individual or group accident and health insurance policy, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

> (H) . . . Each individual policy or group policy of accident and sickness insurance . . . that is delivered, issued for delivery, or renewed in this state, . . . including policies issued by companies subject to Chapter 20, Insurance Code, ...

Revisor's Note

(1) Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, refers to policies of "accident and sickness" insurance. For consistency with modern usage, the revised law substitutes "accident and health" for "accident and sickness."

(2) Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, refers to policies issued by "companies" subject to V.T.I.C. Chapter 20, revised as

Chapter 842. The term most frequently used to describe such a company is "group hospital service corporation." Therefore, the revised law substitutes "group hospital service corporation" for "companies."

Revised Law

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, revised as this chapter. The majority of these articles are revised in this code as Chapter 1201. Section 1356.003 is added to indicate the applicability of those general provisions to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1356.004. EXCEPTION. This chapter does not apply to a plan that provides coverage only for a specified disease or for another limited benefit. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . [Each individual policy or group policy of accident and sickness insurance . . . that is delivered, issued for delivery, or renewed in this

state,] except for policies that provide coverage for specified disease or other limited benefit coverage but . . . .

Revised Law

Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(b) Coverage required by this section:

(1) may not be less favorable than coverage for other radiological examinations under the plan; and

(2) must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . [Each individual policy or group policy of accident and sickness insurance] that covers a female 35 years old or older and [that is delivered, issued for delivery, or renewed in this state, except for policies that provide coverage for specified disease or other limited benefit coverage but including policies issued by companies subject to Chapter 20, Insurance Code,] must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer within the provisions of the policy that is not less favorable than for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors.

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

[Sections 1357.008-1357.050 reserved for expansion]

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Revised Law

Sec. 1357.001. DEFINITIONS. In this subchapter:

(1) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy has been performed and surgical reconstruction of a breast on which mastectomy has not been performed.

(2) "Enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53I, Secs. 1(2), (3).)

Source Law

Art. 21.53I
Sec. 1. In this article:

(2) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

(3) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

(1) Section 1(1), V.T.I.C. Article 21.53I, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1357.002 and

1357.003, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (1) "Health benefit plan" means a plan described by Section 2 of this article.
>
> (2) Section 1(2), V.T.I.C. Article 21.53I, refers to a "mastectomy surgery." The revised law substitutes "mastectomy" for "mastectomy surgery" because the terms are synonymous, and "mastectomy" is the term used throughout this chapter.

Revised Law

Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C.

Art. 21.53I, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.53I, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner" under Article 21.52F of this code. The revised law omits the quoted language as unnecessary because Article 21.52F, revised as Chapter 844 of this code, requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1357.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit, other than benefits for cancer;

(B) only for accidental death or dismemberment;

(C) only for wages or payments in lieu of wages

for a period during which an employee is absent from work because of sickness or injury;

(D) only for credit insurance;

(E) only for dental or vision care;

(F) only for indemnity for hospital confinement; or

(G) as a supplement to a liability insurance policy;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1357.002. (V.T.I.C. Art. 21.53I, Sec. 2(b).)

Source Law

(b) This article does not apply to:
(1) a plan that provides coverage:
(A) only for a specified disease or other limited benefit except for cancer;
(B) only for accidental death or dismemberment;
(C) only for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(D) only for credit insurance;
(E) only for dental or vision care;
(F) only for indemnity for hospital confinement; or
(G) as a supplement to liability insurance;
(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;
(3) workers' compensation insurance coverage;
(4) medical payment insurance issued as part of a motor vehicle insurance policy; or
(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of

this section.

Revised Law

Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) Coverage required under this section:

(1) shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;

(2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and

(3) may not be subject to dollar limits other than the lifetime maximum benefits under the plan. (V.T.I.C. Art. 21.53I, Sec. 3.)

Source Law

> Sec. 3. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:
>
> (1) reconstruction of the breast on which the mastectomy has been performed;
>
> (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
>
> (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.
>
> (b) The coverage described by this section shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee.
>
> (c) The coverage described by this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other benefits under the health benefit plan.
>
> (d) The benefits required by this subchapter may not be subject to dollar limitations other than the health benefit plan's lifetime maximum benefits.

Revised Law

Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a health benefit plan may not:

(1) offer a financial incentive for an enrollee to not receive breast reconstruction or to waive the coverage required under this subchapter;

(2) condition, limit, or deny the eligibility of a person to enroll in the plan or to renew coverage under the terms of the plan solely to avoid the requirements of this subchapter; or

(3) reduce or limit the reimbursement or amount paid to, or otherwise penalize, an attending physician or provider or provide a financial incentive or other benefit to an attending physician or provider to induce the physician or provider to provide care to an enrollee in a manner that is inconsistent with this subchapter.

(b) This section does not prevent an issuer of a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that the physician or provider will receive for care provided in accordance with this subchapter. (V.T.I.C. Art. 21.53I, Sec. 4.)

Source Law

Sec. 4. (a) A health benefit plan may not:

(1) offer a financial incentive for a patient to forgo breast reconstruction or to waive the coverage required by Section 3 of this article;

(2) condition, limit, or deny the eligibility of an enrollee to enroll in the health benefit plan or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this article; or

(3) reduce or limit the reimbursement or payment of, or otherwise penalize, an attending physician or provider or provide financial incentives or other benefits to an attending physician or provider to induce the physician or provider to provide care to an enrollee in a manner inconsistent with this article.

(b) This section may not be construed to prevent a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that physician or provider will receive for care provided in accordance with this article.

Revised Law

Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a

health benefit plan that provides coverage under this subchapter shall provide to each enrollee notice of the availability of the coverage.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53I, Sec. 5.)

Source Law

> Sec. 5. A health benefit plan that provides coverage under this article shall provide notice of the availability of that coverage to each enrollee in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1357.007. RULES. The commissioner may adopt rules to implement this subchapter and to meet the minimum requirements of federal law. (V.T.I.C. Art. 21.53I, Sec. 7.)

Source Law

> Sec. 7. The commissioner may adopt rules to implement this article and to meet the minimum requirements of federal law.

Revisor's Note
(End of Subchapter)

Section 6, V.T.I.C. Article 21.53I, states that the article is severable. The revised law omits the provision as unnecessary because it duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. Those provisions state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

> Sec. 6. If any provision of this article or the application of this article to any person or circumstance is held invalid, the invalidity does not affect a provision or application of this article that can be given effect without the invalid provision or application, and to this end, the provisions of this article are declared to be severable.

[Sections 1357.008-1357.050 reserved for expansion]

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN RELATED PROCEDURES

Revised Law

Sec. 1357.051. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.52G, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Art. 21.52G
Sec. 1. In this article:
(1) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

Section 1(2), V.T.I.C. Article 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1357.052 and 1357.053, specify the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(2) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides coverage only for a specific disease or condition or for hospitalization. (V.T.I.C. Art. 21.52G, Secs. 2(a), (b), as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29

U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(b) This article applies to a health benefit plan that provides coverage only for a specific disease or condition or for hospitalization.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495(b), Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1357.052. (V.T.I.C. Art. 21.52G, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to liability insurance;

(2) a small-employer plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit

plan that provides coverage for the treatment of breast cancer must provide to each enrollee coverage for inpatient care for a minimum of:

(1) 48 hours following a mastectomy; and

(2) 24 hours following a lymph node dissection for the treatment of breast cancer.

(b) A health benefit plan is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

> Sec. 3. (a) A health benefit plan that provides benefits for the treatment of breast cancer must include coverage for inpatient care for an enrollee for a minimum of:
>
> (1) 48 hours following a mastectomy; and
>
> (2) 24 hours following a lymph node dissection for the treatment of breast cancer.
>
> (b) A health benefit plan is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) of this section if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate.

Revised Law

Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) deny the eligibility or continued eligibility of an individual to enroll in the plan or renew coverage under the plan solely to avoid the requirements of this subchapter;

(2) provide money payments or rebates to an enrollee to encourage the enrollee to accept less than the minimum coverage required under this subchapter;

(3) reduce or limit the amount paid to an attending physician, or otherwise penalize the physician, because the physician provided care to an enrollee in accordance with this subchapter; or

(4) provide financial or other incentives to an

attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this subchapter. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

> Sec. 4. The issuer of a health benefit plan may not:
>
> (1) deny to an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this article;
>
> (2) provide money payments or rebates to an enrollee to encourage the enrollee to accept less than the minimum coverage required under Section 3(a) of this article;
>
> (3) reduce or limit the amount paid to an attending physician, or otherwise penalize the physician, because the physician provided care to an enrollee in accordance with this article; or
>
> (4) provide financial or other incentives to an attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this article.

Revised Law

Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

> Sec. 5. Each health benefit plan shall provide written notice to each enrollee under the plan regarding the coverage required by this article. The notice must be provided in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1357.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.52G, Sec. 6, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

> Sec. 6. The commissioner shall adopt rules as necessary to administer this article.

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

[Sections 1358.006-1358.050 reserved for expansion]

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

Revised Law

Sec. 1358.001. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

Art. 21.53D
Sec. 1. In this article:
(1) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

Section 1(2), V.T.I.C. Article 21.53D, as added by Chapter 1285, Acts of the 75th Legislature, Regular

Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1358.002 and 1358.003, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (2) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843;

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement; and

(3) health and accident coverage provided by a risk

pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53D, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

> Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:
>
> (1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
>
> (A) an insurance company;
>
> (B) a group hospital service corporation operating under Chapter 20 of this code;
>
> (C) a fraternal benefit society operating under Chapter 10 of this code;
>
> (D) a stipulated premium insurance company operating under Chapter 22 of this code; or
>
> (E) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
>
> (2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:
>
> (A) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or
>
> (B) another analogous benefit arrangement; or
>
> (3) notwithstanding Section 172.014, Local Government Code, or any other law, health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

Revised Law

Sec. 1358.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) only for dental or vision care; or

(F) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.002. (V.T.I.C. Art. 21.53D, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

(b) This article does not apply to:
(1) a plan that provides coverage:
(A) only for a specified disease;
(B) only for accidental death or dismemberment;
(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(D) as a supplement to liability insurance;
(E) dental or vision care only; or
(F) hospital confinement indemnity coverage only;
(2) a plan written under Chapter 26 of this code;
(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
(4) workers' compensation insurance coverage;
(5) medical payment insurance issued as part of a motor vehicle insurance policy; or
(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revisor's Note

Section 2(b)(2), V.T.I.C. Article 21.53D, as added by Chapter 1285, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan written under

Chapter 26 of this code." The revised law refers to a "small employer health benefit plan written under Chapter 1501." When Article 21.53D was enacted, Chapter 26, codified as Chapter 1501 of this code, addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through the enactment of Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the reference to a "small employer health benefit plan" correctly reflects legislative intent.

Revised Law

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes. (V.T.I.C. Art. 21.53D, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

Sec. 3. (a) The commissioner, in consultation with the Texas Diabetes Council, shall by rule adopt minimum standards for benefits provided to enrollees with diabetes.

Revised Law

Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

(b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan. (V.T.I.C. Art. 21.53D, Secs. 3(b), (c), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

(b) Each health care benefit plan shall provide benefits for the care required by the minimum

standards adopted under Subsection (a) of this section.

(c) The benefits required under this article may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the applicable deductible, coinsurance, or copayment applicable to other similar benefits provided under the plan.

[Sections 1358.006-1358.050 reserved for expansion]

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

Revised Law

Sec. 1358.051. DEFINITIONS. In this subchapter:

(1) "Diabetes equipment" means:

(A) blood glucose monitors, including monitors designed to be used by blind individuals;

(B) insulin pumps and associated appurtenances;

(C) insulin infusion devices; and

(D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

(A) test strips for blood glucose monitors;

(B) visual reading and urine test strips;

(C) lancets and lancet devices;

(D) insulin and insulin analogs;

(E) injection aids;

(F) syringes;

(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(H) glucagon emergency kits.

(3) "Nutrition counseling" has the meaning assigned by Section 701.002, Occupations Code.

(4) "Qualified enrollee" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent diabetes;

(B) elevated blood glucose levels induced by

pregnancy; or

(C) another medical condition associated with elevated blood glucose levels. (V.T.I.C. Art. 21.53G, Secs. 1(1), (2), (4), (5).)

Source Law

Art. 21.53G
Sec. 1. In this article:
(1) "Diabetes equipment" means:
(A) blood glucose monitors, including monitors designed to be used by blind individuals;
(B) insulin pumps and associated appurtenances;
(C) insulin infusion devices; and
(D) podiatric appliances for the prevention of complications associated with diabetes.
(2) "Diabetes supplies" means:
(A) test strips for blood glucose monitors;
(B) visual reading and urine test strips;
(C) lancets and lancet devices;
(D) insulin and insulin analogs;
(E) injection aids;
(F) syringes;
(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and
(H) glucagon emergency kits.

(4) "Qualified insured" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:
(A) insulin dependent or noninsulin dependent diabetes;
(B) elevated blood glucose levels induced by pregnancy; or
(C) another medical condition associated with elevated blood glucose levels.
(5) "Nutrition counseling" has the meaning assigned by Section 2, Licensed Dietitian Act (Article 4512h, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 1(3), V.T.I.C. Article 21.53G, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1358.052 and 1358.053, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(3) "Health benefit plan" means a plan described by Section 2 of this

article.

(2) Section 1(4), V.T.I.C. Article 21.53G, defines "qualified insured" to include certain individuals eligible for coverage under a health benefit plan. "Insured" is a term used in conjunction with traditional insurance. This subchapter applies to health benefit plans offered by entities such as health maintenance organizations that are not traditional insurers. Consequently, "enrollee" is a more accurate term than "insured," and the revised law substitutes "enrollee" for "insured."

(3) Section 1(5), V.T.I.C. Article 21.53G, refers to Section 2, Licensed Dietitian Act (Article 4512h, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Section 701.002, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884;

(v) a reciprocal exchange operating under

Chapter 942; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53G, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code;

(v) a reciprocal exchange operating under Chapter 19 of this code; or

(vi) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.53G, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice

Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1358.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.052. (V.T.I.C. Art. 21.53G, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for:

(1) diabetes equipment;

(2) diabetes supplies; and

(3) diabetes self-management training in accordance with the requirements of Section 1358.055.

(b) A health benefit plan may require a deductible,

copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions. (V.T.I.C. Art. 21.53G, Secs. 3, 6.)

Source Law

> Sec. 3. A health benefit plan that provides benefits for the treatment of diabetes and associated conditions must provide coverage to each qualified insured for:
>
> (1) diabetes equipment;
>
> (2) diabetes supplies; and
>
> (3) diabetes self-management training programs.
>
> Sec. 6. Benefits required under this article may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance required by the health benefit plan for benefits under this article may not exceed the deductible, copayment, or coinsurance required by the health benefit plan for treatment of other analogous chronic medical conditions.

Revised Law

Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a) Diabetes self-management training must be provided by a health care practitioner or provider who is:

(1) licensed, registered, or certified in this state to provide appropriate health care services; and

(2) acting within the scope of practice authorized by the license, registration, or certification.

(b) For purposes of this subchapter, "self-management training" includes:

(1) training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and

(3) periodic or episodic continuing education training prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:

(1) a diabetes self-management training program recognized by the American Diabetes Association;

(2) diabetes self-management training provided by a multidisciplinary team:

(A) the nonphysician members of which are coordinated by:

(i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

(ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) diabetes self-management training provided by a

diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) diabetes self-management training that provides one or more of the following components:

(A) a nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) a pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) a component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) a component provided by a physician.

(d) An individual may not provide a component of diabetes self-management training under Subsection (c)(4) unless:

(1) the subject matter of the component is within the scope of the individual's practice; and

(2) the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health. (V.T.I.C. Art. 21.53G, Sec. 4.)

Source Law

> Sec. 4. (a) Diabetes self-management training under this article must be provided by a health care practitioner or provider who is licensed, registered, or certified in this state to provide appropriate health care services and who is acting within the scope of practice authorized by the practitioner's or provider's license, registration, or certification. Self-management training includes:
>
> (1) training provided to a qualified insured after the initial diagnosis of diabetes in the care and management of that condition, including nutrition counseling and proper use of diabetes equipment and supplies;
>
> (2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified insured's symptoms or condition that requires changes

in the qualified insured's self-management regime; and

(3) periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

(b) Coverage for diabetes self-management training provided by a health benefit plan under this article to a qualified insured must include coverage for the following, if provided on the written order of a physician or health care practitioner, including the written order of a health care practitioner practicing under protocols jointly developed with a physician:

(1) a diabetes self-management training program recognized by the American Diabetes Association;

(2) diabetes self-management training given by a multidisciplinary team:

(A) the non-physician members of which are coordinated by:

(i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

(ii) a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) diabetes self-management training in which one or more of the following components are provided:

(A) the nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) the pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) any component of the training provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) any component of the training provided by a physician.

(c) A person may not provide a component of diabetes self-management training under Subsection (b)(4) of this section unless the subject matter of the component is within the scope of the person's practice

and the person meets the education requirements, as determined by the person's licensing agency, in consultation with the commissioner of public health.

Revised Law

Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND SUPPLIES. A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate. (V.T.I.C. Art. 21.53G, Sec. 5.)

Source Law

Sec. 5. In addition to the benefits required under Sections 3 and 4 of this article, on the approval of the United States Food and Drug Administration of new or improved diabetes equipment or diabetes supplies, including improved insulin or other prescription drugs, each health benefit plan subject to this article must include coverage of the new or improved equipment or supplies if medically necessary and appropriate as determined by a physician or other health care practitioner.

Revised Law

Sec. 1358.057. RULES. (a) The commissioner shall adopt rules necessary to implement this subchapter.

(b) In adopting rules under this section, the commissioner may consult with the commissioner of public health and other appropriate entities. (V.T.I.C. Art. 21.53G, Sec. 7.)

Source Law

Sec. 7. The commissioner shall adopt rules as necessary for the implementation of this article. The commissioner may consult with the commissioner of public health and other appropriate entities in adopting rules under this section.

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA OR OTHER HERITABLE DISEASES

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA OR OTHER HERITABLE DISEASES

Revised Law

Sec. 1359.001. DEFINITIONS. In this chapter:

(1) "Heritable disease" means an inherited disease that may result in mental or physical retardation or death.

(2) "Phenylketonuria" means an inherited condition that, if not treated, may cause severe mental retardation. (V.T.I.C. Art. 3.79, Secs. 1(2), (3).)

Source Law

Sec. 1. In this article:

(2) "Heritable disease" means an inherited disease that may result in mental or physical retardation or death.

(3) "Phenylketonuria" means an inherited condition that may cause severe mental retardation if not treated.

Revised Law

Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that is a group policy, contract, or certificate of health insurance or an evidence of coverage delivered, issued for delivery, or renewed in this state by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.79, Sec. 1(1).)

Source Law

Art. 3.79

Sec. 1. In this article:

(1) "Health insurance policy" means any group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurance company, including a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revisor's Note

Section 1(1), V.T.I.C. Article 3.79, defines "health insurance policy." "Insurance policy" is a term used in conjunction with traditional insurance. Included in the definition of "health insurance policy" are evidences of coverage issued by health maintenance organizations. The coverage provided by this type of document is not insurance coverage, and this type of coverage document is not typically described as an "insurance policy." Therefore, "group health benefit plan" is a more accurate term than "health insurance policy," and the revised law substitutes "group health benefit plan" for "health insurance policy."

Revised Law

Sec. 1359.003. COVERAGE REQUIRED. (a) A group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease.

(b) The group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician. (V.T.I.C. Art. 3.79, Sec. 2.)

Source Law

Sec. 2. Each health insurance policy shall include coverage for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician.

CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING TEMPOROMANDIBULAR JOINT

CHAPTER 1360. DIAGNOSIS AND TREATMENT

AFFECTING TEMPOROMANDIBULAR JOINT

Revised Law

Sec. 1360.001. DEFINITION. In this chapter, "temporomandibular joint" includes the jaw and the craniomandibular joint. (V.T.I.C. Art. 21.53A, Sec. 3(a) (part).)

Source Law

(a) . . . For purposes of this section, the temporomandibular joint includes the jaw and the craniomandibular joint.

Revised Law

Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered or issued for delivery in this state that:

(1) provides benefits for dental, medical, or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this

code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53A, Secs. 2(a), 3(a) (part).)

Source Law

Sec. 2. (a) This article applies to a group health benefit plan that:

(1) provides benefits for dental, medical, or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Sec. 3. (a) Each health benefit plan delivered or issued for delivery in this state . . . .

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53A, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 2(a), V.T.I.C. Article 21.53A, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1360.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) a small employer health benefit plan written under Chapter 1501;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1360.002. (V.T.I.C. Art. 21.53A, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) workers' compensation insurance coverage;

(4) a small employer plan written under Chapter 26 of this code;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary as a result of:

(1) an accident;

(2) a trauma;

(3) a congenital defect;

(4) a developmental defect; or

(5) a pathology.

(b) Coverage required under this section may be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. (V.T.I.C. Art. 21.53A, Secs. 3(a) (part), (b), (c).)

Source Law

> Sec. 3. (a) Each health benefit plan . . . that provides benefits for the medically necessary diagnostic or surgical treatment of skeletal joints must provide comparable coverage as provided by this article for the medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint. . . .
>
> (b) Each health benefit plan shall provide coverage under this article for diagnosis or surgical treatment medically necessary as a result of:
>
> (1) an accident;
>
> (2) a trauma;
>
> (3) a congenital defect;
>
> (4) a developmental defect; or
>
> (5) a pathology.
>
> (c) All other provisions generally applicable to surgical treatment under the health benefit plan may be applied to the benefits required under this article, including any requirements for precertification of benefits.

Revised Law

Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a) This chapter does not require a health benefit plan to provide coverage for dental services if dental services are not otherwise scheduled or provided as part of the coverage provided under the

plan.

(b) A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or by the dentist providing the dental care. (V.T.I.C. Art. 21.53A, Sec. 4.)

Source Law

> Sec. 4. (a) This article does not require a health benefit plan to provide dental services if dental services are not otherwise scheduled or provided as a part of the benefits covered under the health benefit plan.
>
> (b) A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or the dentist providing the dental care.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53A, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1360.002 and 1360.003, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> Art. 21.53A
>
> Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

Revised Law

Sec. 1361.001. DEFINITION. In this chapter, "qualified enrollee" means an individual entitled to coverage under a group health benefit plan who is:

(1) a postmenopausal woman who is not receiving estrogen replacement therapy;

(2) an individual with:

(A) vertebral abnormalities;

(B) primary hyperparathyroidism; or

(C) a history of bone fractures; or

(3) an individual who is:

(A) receiving long-term glucocorticoid therapy; or

(B) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. (V.T.I.C. Art. 21.53C, Secs. (b), (c) (part).)

Source Law

(b) "Qualified individual" means:
(1) a postmenopausal woman who is not receiving estrogen replacement therapy;
(2) an individual with:
(A) vertebral abnormalities;
(B) primary hyperparathyroidism; or
(C) a history of bone fractures; or
(3) an individual who is:
(A) receiving long-term glucocorti coid therapy; or
(B) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
(c) [A group health insurance policy must provide coverage for a qualified individual] covered by the policy . . . .

Revised Law

Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered, issued for delivery, or renewed in this state that provides coverage for medical or surgical expenses incurred as a result of accident or sickness, including:

(1) a group insurance policy;

(2) a group contract issued by a group hospital service corporation operating under Chapter 842; and

(3) a group contract issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 21.53C, Sec. (a).)

Source Law

Art. 21.53C. (a) In this article, "group health insurance policy" means a group insurance policy, group hospital service contract, or group contract issued by a health maintenance organization that is delivered, issued for delivery, or renewed in this state and that provides benefits for medical or surgical expenses incurred as a result of accident or sickness.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.53C, defines "group health insurance policy." "Insurance policy" is a term used in conjunction with traditional insurance. Included within the definition of "group health insurance policy" are group contracts issued by health maintenance organizations. The coverage provided by that type of document is not insurance coverage, and that type of coverage document is not typically described as an "insurance policy." Therefore, "group health benefit plan" is a more accurate term than "group health insurance policy," and the revised law substitutes "group health benefit plan" for "group health insurance policy."

(2) Section (a), V.T.I.C. Article 21.53C, refers to a "group hospital service contract," meaning a contract issued by a group hospital service corporation, and a "group contract issued by a health maintenance organization." For clarity and the convenience of the reader, the revised law adds a reference to Chapters 842 and 843, respectively, which are the chapters under which group hospital service corporations and health maintenance organizations operate.

Revised Law

Sec. 1361.003. COVERAGE REQUIRED. A group health benefit plan must provide to a qualified enrollee coverage for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures

associated with osteoporosis. (V.T.I.C. Art. 21.53C, Sec. (c) (part).)

Source Law

> (c) A group health insurance policy must provide coverage for a qualified individual . . . for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis.

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Revised Law

Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee

Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code;

(3) is offered by any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(4) notwithstanding Section 172.014, Local Government Code, or any other law, provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

(2) Section 2(a), V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state.

The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

Revised Law

Sec. 1362.002. EXCEPTION. This chapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1362.001. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance; or

(E) only for indemnity for hospital confinement;

(2) a plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revisor's Note

Section 2(b)(2), V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan written under Chapter 26 of this code." The revised law refers to a "small employer health benefit plan written under Chapter 1501." When Article 21.53F was enacted, Chapter 26 addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through the enactment of Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the reference to "a small employer health benefit plan" correctly reflects legislative intent.

Revised Law

Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) Coverage required under this section includes at a minimum:

(1) a physical examination for the detection of

prostate cancer; and

(2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:

(A) is at least 50 years of age and is asymptomatic; or

(B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor. (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

> Sec. 3. (a) A health benefit plan that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer.
>
> (b) The minimum benefits provided under Subsection (a) of this section must include:
>
> (1) a physical examination for the detection of prostate cancer; and
>
> (2) a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is:
>
> (A) at least 50 years of age and asymptomatic; or
>
> (B) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Revised Law

Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

> Sec. 4. Each health benefit plan shall provide written notice to each person enrolled in the plan regarding the coverage required by this article. The notice must be provided in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1362.005. RULES. The commissioner shall adopt rules necessary to administer this chapter. (V.T.I.C. Art. 21.53F, Sec.

5, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to administer this article.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1362.001 and 1362.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> Art. 21.53F
> Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Revised Law

Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a Lloyd's plan operating under Chapter 941;

(v) a stipulated premium company operating under Chapter 884; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation operating under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53S, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a Lloyd's plan operating under Chapter 18 of this code;

(v) a stipulated premium

insurance company operating under Chapter 22 of this code; or

(vi) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that is certified under Section 162.001, Occupations Code, and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or

(3) notwithstanding Section 172.014, Local Government Code, or any other law, provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.53S, refers to an approved nonprofit health corporation that is "certified under Section 162.001, Occupations Code," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference in Article 21.53S to certification under Section 162.001, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires an approved nonprofit health corporation to be certified under Section 162.001, Occupations Code, as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner's issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1363.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited

benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1363.001. (V.T.I.C. Art. 21.53S, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance; or

(E) only for indemnity for hospital confinement;

(2) a small employer plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a

nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum coverage required under this section must include:

(1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or

(2) a colonoscopy performed every 10 years. (V.T.I.C. Art. 21.53S, Sec. 3.)

Source Law

Sec. 3. (a) A health benefit plan that provides benefits for screening medical procedures must provide coverage for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum benefits provided under Subsection (a) of this section must:

(1) include:

(A) a fecal occult blood test performed annually; and

(B) a flexible sigmoidoscopy performed every five years; or

(2) include a colonoscopy performed every 10 years.

Revised Law

Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53S, Sec. 4.)

Source Law

Sec. 4. Each health benefit plan shall provide

written notice to each person enrolled in the plan regarding the coverage required by this article. The notice must be provided in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1363.005. RULES. The commissioner shall adopt rules as necessary to administer this chapter. (V.T.I.C. Art. 21.53S, Sec. 5.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to administer this article.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53S, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1363.001 and 1363.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53S
Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

[Sections 1364.005-1364.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

[Sections 1364.054-1364.100 reserved for expansion]

Revised Law

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that is delivered, issued for delivery, or renewed and that is:

(1) a group accident and health insurance policy;

(2) a group contract issued by a group hospital service corporation operating under Chapter 842; or

(3) a group evidence of coverage issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Source Law

> Sec. 3C. [No] group policy of accident, health, or accident and health insurance including group contracts issued by any hospital and medical service plan corporation subject to Chapter 20 of this code and health maintenance organization subject to Chapter 20A of this code . . . delivered or issued for delivery or renewed . . . .

Revisor's Note

(1) Section 3C, V.T.I.C. Article 3.51-6, as added by Section 14, Chapter 1041, Acts of the 71st Legislature, Regular Session, 1989, refers to a "group policy of accident, health, or accident and health insurance." The revised law substitutes "group accident and health insurance policy" for "group policy of accident, health, or accident and health insurance" to provide for consistent use of terminology throughout this code.

(2) Section 3C, V.T.I.C. Article 3.51-6, as added by Section 14, Chapter 1041, Acts of the 71st

Legislature, Regular Session, 1989, refers to a "hospital and medical service plan corporation" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to describe such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "hospital and medical service plan corporation" to provide for consistent use of terminology throughout this code.

(3) Section 3C, V.T.I.C. Article 3.51-6, as added by Section 14, Chapter 1041, Acts of the 71st Legislature, Regular Session, 1989, refers to group "contracts" issued by a health maintenance organization subject to V.T.I.C. Chapter 20A, revised in relevant part as Chapter 843 of this code. The term most frequently used to describe the type of coverage document issued by a health maintenance organization is "evidence of coverage." Consequently, the revised law substitutes "evidence of coverage" for "contracts" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1364.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the department; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Source Law

Sec. 4. The provisions of this article shall not be applicable to:

(1) credit accident and health insurance policies subject to Article 3.53 of the Insurance Code, as amended;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance prior to April 1, 1975;

(3) accident and health coverages that are incidental to any form of group automobile, casualty, property, or workmen's compensation--employers' liability policies promulgated or approved by the State Board of Insurance;

(4) any policy or contract of insurance with a state agency, department, or board providing health services to all eligible persons under Chapter 32, Human Resources Code, or in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended, under a state plan.

Revisor's Note

(1) Section 4(1), V.T.I.C. Article 3.51-6, refers to "Article 3.53 of the Insurance Code, as amended." The revised law omits "as amended" because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

(2) Section 4(3), V.T.I.C. Article 3.51-6, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The reference to the board has been

changed appropriately.

Revised Law

Sec. 1364.003. PROHIBITION. A group health benefit plan may not exclude or deny coverage for:

(1) human immunodeficiency virus (HIV);

(2) acquired immune deficiency syndrome (AIDS); or

(3) an HIV-related illness. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Source Law

> Sec. 3C. No group policy [of accident, health, or accident and health insurance including group contracts issued by any hospital and medical service plan corporation subject to Chapter 20 of this code and health maintenance organization subject to Chapter 20A of this code] shall be [delivered or issued for delivery or renewed] that excludes or denies coverage for HIV, AIDS, or HIV-related illnesses.

Revised Law

Sec. 1364.004. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

Source Law

> Sec. 5. The State Board of Insurance is authorized to issue such rules and regulations as may be necessary to carry out the various provisions of this article. Rules and regulations promulgated pursuant to this article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

Revisor's Note

Section 5, V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 1364.005-1364.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

Revised Law

Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Source Law

> Art. 3.51-6D. (a) [Except as provided by Subsection (b) of this article, an insurer that delivers or issues for delivery a policy or contract of group health insurance in this state, including a group hospital service corporation under Chapter 20 of this code, may not cancel during the term of the policy or contract the coverage of a person covered by that policy or contract because that person has been diagnosed as having or has been or is being treated for HIV or AIDS] as defined by Section 81.101, Health and Safety Code.

Revised Law

Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that delivers or issues for delivery a group health insurance policy or contract in this state, including a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Source Law

> Art. 3.51-6D. (a) [Except as provided by Subsection (b) of this article, an insurer] that delivers or issues for delivery a policy or contract of group health insurance in this state, including a group hospital service corporation under Chapter 20 of this code, [may not cancel during the term of the policy or contract the coverage of a person covered by that policy or contract because that person has been diagnosed as having or has been or is being treated for HIV or AIDS as defined by Section 81.101, Health and Safety Code.]

Revised Law

Sec. 1364.053. PROHIBITION. (a) Except as provided by Subsection (b), an insurer may not cancel during the term of a group health insurance policy or contract an individual's coverage provided by the policy or contract because the individual:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(b) The insurer may cancel the coverage provided by the

policy or contract for fraud or misrepresentation in the obtaining of coverage by failure to disclose a diagnosis of AIDS or an HIV-related condition. (V.T.I.C. Art. 3.51-6D, Subsecs. (a) (part), (b).)

Source Law

> Art. 3.51-6D. (a) Except as provided by Subsection (b) of this article, an insurer . . . may not cancel during the term of the policy or contract the coverage of a person covered by that policy or contract because that person has been diagnosed as having or has been or is being treated for HIV or AIDS . . . .
>
> (b) An insurer may cancel coverage under a policy or contract covered by Subsection (a) of this article if there was fraud or misrepresentation in obtaining the coverage by not disclosing a diagnosis of AIDS and HIV-related conditions.

[Sections 1364.054-1364.100 reserved for expansion]

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Revised Law

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES. A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that excludes or limits coverage or services for:

(1) acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service; or

(2) human immunodeficiency virus infection. (V.T.I.C. Art. 3.51-5A, Subsec. (a) (part).)

Source Law

> Art. 3.51-5A. (a) A municipality, county, school district, district created under Article III, Section 52, or Article XVI, Section 59, of the Texas Constitution, or other political subdivision of the state that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to its officers or employees or to both its officers and employees may not contract for or provide coverage that:
>
> (1) excludes or limits coverage or services for acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service, or human immunodeficiency virus infection; or

. . . .

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.51-5A, refers to "[a] municipality, county, school district, district created under Article III, Section 52, or Article XVI, Section 59, of the Texas Constitution, or other political subdivision of the state." The revised law substitutes the term "political subdivision" for the quoted language because each type of entity specified is included in the meaning of "political subdivision."

(2) Section (a)(1), V.T.I.C. Article 3.51-5A, refers to the "Centers for Disease Control of the United States Public Health Service." The revised law substitutes the current name for these centers, "Centers for Disease Control and Prevention of the United States Public Health Service."

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Revised Law

Sec. 1365.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital and medical coverage on an expense-incurred, service, or prepaid basis, including a group policy, contract, or plan that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Source Law

> (G) Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, and health maintenance organizations transacting health insurance or providing other health coverage in this state . . . under group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service or prepaid basis . . . .

Revisor's Note

Section (G), V.T.I.C. Article 3.70-2, refers to "nonprofit hospital and medical service plan corporations" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "nonprofit hospital and medical service plan corporations" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to Section (G), V.T.I.C. Article 3.70-2, revised as this chapter. The majority of these articles are revised in

this code as Chapter 1201. Section 1365.002 is added to indicate the applicability of those general provisions to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group health benefit plan issuer shall offer and make available under the plan coverage for the necessary care and treatment of loss or impairment of speech or hearing.

(b) Coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan; and

(2) must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as coverage for physical illness generally under the plan. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Source Law

> (G) [Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, and health maintenance organizations transacting health insurance or providing other health coverage in this state] shall offer and make available, [under group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service or prepaid basis,] benefits for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors. . . .

Revised Law

Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT ALTERNATIVE COVERAGE. An offer of coverage required under Section 1365.003 is subject to the right of the group contract holder to reject the coverage or to select an alternative level of coverage that is offered by or negotiated with the group health benefit plan issuer. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Source Law

(G) . . . Such offer of benefits shall be

subject to the right of the group policy or contract holder to reject the coverage or to select any alternative level of benefits if such right is offered by or negotiated with such insurer, service plan corporation, or health maintenance organization.

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

[Sections 1366.008-1366.050 reserved for expansion]

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Revised Law

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for hospital, medical, or surgical expenses incurred as a result of accident or sickness, including a group health insurance policy, health care service contract or plan, or other provision of group health benefits, coverage, or services in

this state that is issued, entered into, or provided by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; or

(4) an employer, multiple employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plan, program, or arrangement. (V.T.I.C. Art. 3.51-6, Sec. 3A(a) (part).)

Source Law

> Sec. 3A. (a) All insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and all employer, multiple-employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plans, programs, or arrangements that either issue group health insurance policies, enter into health care service contracts or plans, or provide for group health benefits, coverage, or services in this state for hospital, medical, or surgical expenses incurred as a result of accident or sickness [shall offer and make available . . . coverage] . . . .

Revisor's Note

Section 3A(a), V.T.I.C. Article 3.51-6, refers to "nonprofit hospital and medical service plan corporations" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "nonprofit hospital and medical service plan corporations" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1366.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy

subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident and health coverages that are incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Source Law

> Sec. 4. The provisions of this article shall not be applicable to:
> (1) credit accident and health insurance policies subject to Article 3.53 of the Insurance Code, as amended;
> (2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance prior to April 1, 1975;
> (3) accident and health coverages that are incidental to any form of group automobile, casualty, property, or workmen's compensation--employers' liability policies promulgated or approved by the State Board of Insurance;
> (4) any policy or contract of insurance with a state agency, department, or board providing health services to all eligible persons under Chapter 32, Human Resources Code, or in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended, under a state plan.

Revisor's Note

(1) Section 4(1), V.T.I.C. Article 3.51-6, refers to "Article 3.53 of the Insurance Code, as amended." The revised law omits "as amended" because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to

any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

(2) Section 4(3), V.T.I.C. Article 3.51-6, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The reference to the board has been changed appropriately.

Revised Law

Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject to this subchapter, an issuer of a group health benefit plan that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures.

(b) Benefits for in vitro fertilization procedures required under this section must be provided to the same extent as benefits provided for other pregnancy-related procedures under the plan. (V.T.I.C. Art. 3.51-6, Secs. 3A(a) (part), (b), (d).)

Source Law

(a) [All insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and all employer, multiple-employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plans, programs, or arrangements that either issue group health insurance policies, enter into health care service contracts or plans, or provide for group health benefits, coverage, or services in this state for hospital, medical, or surgical expenses incurred as a result of accident or sickness] shall offer and make available to each group policyholder, contract holder, employer, multiple-employer, union, association, or trustee under a group policy, contract, plan, program, or arrangement that provides hospital, surgical, and medical benefits, coverage for services and benefits on an expense incurred, service, or prepaid basis for out-patient expenses that may arise from in vitro fertilization procedures, if the group insurance policy, contract, plan, program, or arrangement

otherwise provides pregnancy-related benefits for the insureds, enrollees, subscribers, employees, members, or other persons covered under the policy contract, plan, program, or arrangement.

(b) An offer made under Subsection (a) of this section is subject to this section.

(d) Benefits for in vitro fertilization procedures must be provided to the same extent as the benefits provided for other pregnancy-related procedures under the policy, contract, plan, program, or arrangement.

Revisor's Note

Section 3A(a), V.T.I.C. Article 3.51-6, requires an issuer of a group health benefit plan to provide certain coverage to each "group policyholder, contract holder, employer, multiple-employer, union, association, or trustee" under the plan. For drafting convenience, the revised law substitutes "holder or sponsor" for the quoted language because the entities listed are the types of entities that would hold or sponsor a group health benefit plan to which this subchapter applies.

Revised Law

Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer under Section 1366.003 to provide coverage for in vitro fertilization procedures must be in writing. (V.T.I.C. Art. 3.51-6, Sec. 3A(c).)

Source Law

(c) A rejection of an offer to provide the coverage for services or benefits provided by Subsection (a) of this section must be in writing.

Revised Law

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The coverage offered under Section 1366.003 is required only if:

(1) the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan;

(2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine. (V.T.I.C. Art. 3.51-6, Sec. 3A(e).)

Source Law

(e) The offer to make the coverage available is required only under the following conditions:

(1) the patient for the in vitro fertilization procedure is an insured, enrollee, subscriber, member, or otherwise covered employee or person under the policy, contract, plan, program, or arrangement;

(2) the fertilization or attempt at fertilization of the patient's oocytes is made only with the patient's spouse's sperm;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with one or more of the following conditions:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy, contract, plan, program, or arrangement; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology

guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Revisor's Note

(1) Section 3A(e)(5), V.T.I.C. Article 3.51-6, refers to the "American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics." The revised law omits the quoted language because the American College of Obstetricians and Gynecologists (the proper name of "American College of Obstetric and Gynecology") no longer has guidelines for in vitro fertilization clinics.

(2) Section 3A(e)(5), V.T.I.C. Article 3.51-6, refers to the "American Fertility Society." The revised law substitutes "American Society for Reproductive Medicine" for "American Fertility Society" because that is now the name of that organization.

Revised Law

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE. An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is not required to offer coverage for in vitro fertilization under Section 1366.003. (V.T.I.C. Art. 3.51-6, Sec. 3A(f).)

Source Law

(f) An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is exempt from this section's requirement to offer coverage for in vitro fertilization.

Revised Law

Sec. 1366.007. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

Source Law

> Sec. 5. The State Board of Insurance is authorized to issue such rules and regulations as may be necessary to carry out the various provisions of this article. Rules and regulations promulgated pursuant to this article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

Revisor's Note

Section 5, V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 1366.008-1366.050 reserved for expansion]

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

Revised Law

Sec. 1366.051. SHORT TITLE. This subchapter may be cited as the Lee Alexandria Hanley Act. (V.T.I.C. Art. 21.53F, Sec. 1, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

> Art. 21.53F
> Sec. 1. This article may be cited as the Lee Alexandria Hanley Act.

Revised Law

Sec. 1366.052. DEFINITIONS. In this subchapter:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth to a child or who attends a newborn child.

(2) "Postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. (V.T.I.C. Art. 21.53F, Secs. 2(1), 5(c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 2. In this article:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth or who attends the newborn child.

[Sec. 5]

(c) For purposes of this section, "postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. . . .

Revisor's Note

Section 2(3), V.T.I.C. Article 21.53F, as added by Chapter 832, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 3 of that article, revised as Sections 1366.053 and 1366.054, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(3) "Health benefit plan" means a plan described by Section 3 of this article.

Revised Law

Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53F, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 3. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) Section 3(a), V.T.I.C. Article 21.53F, as added by Chapter 832, Acts of the 75th Legislature, Regular Session, 1997, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 3(a), V.T.I.C. Article 21.53F, as added by Chapter 832, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a),

Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1366.054. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so

comprehensive that the policy is a health benefit plan as described by Section 1366.053. (V.T.I.C. Art. 21.53F, Sec. 3(b), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

(b) This article does not apply to:
(1) a plan that provides coverage:
(A) only for a specified disease or other limited benefit;
(B) only for accidental death or dismemberment;
(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(D) as a supplement to liability insurance;
(E) for credit insurance;
(F) only for dental or vision care; or
(G) only for indemnity for hospital confinement;
(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
(3) workers' compensation insurance coverage;
(4) medical payment insurance issued as part of a motor vehicle insurance policy; or
(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

(1) 48 hours after an uncomplicated vaginal delivery; and

(2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required under Subsection (a) unless:

(1) the attending physician determines that inpatient care is medically necessary; or

(2) the woman requests inpatient care.

(c) For purposes of Subsection (a), the attending physician shall determine whether a delivery is complicated.

(d) This section does not require a woman who is eligible for coverage under a health benefit plan to:

(1) give birth to a child in a hospital or other health care facility; or

(2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

> Sec. 4. (a) A health benefit plan that provides maternity benefits, including benefits for childbirth, must include coverage for inpatient care for a mother and her newborn child in a health care facility for a minimum of:
>
> (1) 48 hours following an uncomplicated vaginal delivery; and
>
> (2) 96 hours following an uncomplicated delivery by caesarean section.
>
> (b) Notwithstanding Subsection (a) of this section, a health benefit plan that provides coverage for in-home postdelivery care to a mother and her newborn child is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) of this section unless that inpatient care is determined to be medically necessary by an attending physician or is requested by the mother.
>
> (c) For purposes of Subsection (a) of this section, the determination as to whether a delivery is complicated shall be made by the attending physician.
>
> (d) This article does not require a mother who is eligible for coverage under a health benefit plan to:
>
> (1) give birth in a hospital or other health care facility; or
>
> (2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child.

Revised Law

Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED. (a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section

1366.055(a), a health benefit plan must provide to the woman and child coverage for timely postdelivery care.

(b) The timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that care.

(c) The postdelivery care may be provided by a physician, registered nurse, or other appropriate licensed health care provider.

(d) Subject to Subsection (e), the postdelivery care may be provided at:

(1) the woman's home;

(2) a health care provider's office;

(3) a health care facility; or

(4) another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home. (V.T.I.C. Art. 21.53F, Secs. 5(a), (b), (c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

> Sec. 5. (a) If a decision is made to discharge a mother or newborn child from inpatient care before the expiration of the minimum hours of coverage of inpatient care required under Section 4(a) of this article, the health benefit plan must provide coverage for timely postdelivery care. That care may be provided to the mother and child by a physician, registered nurse, or other appropriate licensed health care provider and may be provided at:
>
> (1) the mother's home, a health care provider's office, or a health care facility; or
>
> (2) another location determined to be appropriate under rules adopted by the commissioner.
>
> (b) The coverage required under Subsection (a) of this section must allow the mother the option to have the care provided in the mother's home.
>
> (c) . . . The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

Revised Law

Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) modify the terms and conditions of coverage based

on a request by an enrollee for less than the minimum coverage required under Section 1366.055(a);

(2) offer to a woman who has given birth to a child a financial incentive or other compensation the receipt of which is contingent on the waiver by the woman of the minimum coverage required under Section 1366.055(a);

(3) refuse to accept a physician's recommendation for inpatient care made in consultation with the woman who has given birth to a child if the period of inpatient care recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by:

(A) the American College of Obstetricians and Gynecologists;

(B) the American Academy of Pediatrics; or

(C) another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;

(4) reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or

(5) penalize a physician for recommending inpatient care for a woman or the woman's newborn child by:

(A) refusing to permit the physician to participate as a provider in the health benefit plan;

(B) reducing payments made to the physician;

(C) requiring the physician to:

(i) provide additional documentation; or

(ii) undergo additional utilization review; or

(D) imposing other analogous sanctions or disincentives. (V.T.I.C. Art. 21.53F, Sec. 6, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 6. A health benefit plan may not:

(1) modify the terms and conditions of coverage based on the determination by a person enrolled in the health benefit plan to request less than the minimum coverage required under Section 4(a) of this article;

(2) offer to the mother of a newborn child financial incentives or other compensation the receipt of which is contingent on the waiver by the mother of the minimum hours of coverage of inpatient care required under Section 4(a) of this article;

(3) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother of the newborn child if the period recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;

(4) reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or

(5) penalize a physician for recommending inpatient care for a mother or her newborn child by:

(A) refusing to allow the physician to participate as a provider within the health benefit plan;

(B) reducing payments made to the physician;

(C) requiring the physician to provide additional documentation or undergo additional utilization review; or

(D) imposing other analogous sanctions or disincentives.

Revised Law

Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each individual enrolled in the plan written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53F, Secs. 2(2), 7, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

[Sec. 2. In this article:]

(2) "Enrollee" means an individual enrolled in a health benefit plan.

Sec. 7. In accordance with rules adopted by the commissioner, each health benefit plan must provide to each enrollee under the plan written notice regarding the coverage required by this article.

Revised Law

Sec. 1366.059. RULES. The commissioner shall adopt rules

necessary to administer this subchapter. (V.T.I.C. Art. 21.53F, Sec. 8, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 8. The commissioner shall adopt rules as necessary to administer this article.

CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Revised Law

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan delivered or issued for delivery in this state that is an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

Source Law

> (E) [No] individual policy or group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code, as amended, delivered or issued for delivery to any person in this state . . . .

Revisor's Note

(1) Section (E), V.T.I.C. Article 3.70-2, refers to an individual or group policy of "accident and sickness" insurance. For consistency with modern usage, the revised law substitutes "accident and health" for "accident and sickness" throughout this chapter.

(2) Section (E), V.T.I.C. Article 3.70-2, refers to "policies issued by companies" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a company is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "companies" to provide for consistent use of terminology throughout this code.

(3) Section (E), V.T.I.C. Article 3.70-2, refers to Chapter 20, Insurance Code, "as amended." The revised law omits the reference to amendments as

unnecessary because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, states that a reference to a statute includes reenactments, revisions, or amendments of that statute.

Revised Law

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (E), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11. The majority of these articles, which include general provisions applicable to Section (E), V.T.I.C. Article 3.70-2, are revised in this code as Chapter 1201. Section 1367.002 is added to indicate the applicability of those general provisions in this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

Revised Law

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED. A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not be issued in this state if the plan excludes or limits:

(1) initial coverage of a newborn child for a period of

time; or

(2) coverage for congenital defects of a newborn child. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

Source Law

(E) No [individual policy or group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code,] . . . which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

Revisor's Note

Section (E), V.T.I.C. Article 3.70-2, refers to a "newborn infant." For consistency throughout this subchapter, the revised law substitutes "newborn child" for "newborn infant."

[Sections 1367.004-1367.050 reserved for expansion]

SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Revised Law

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 20 of this code;

(C) a fraternal benefit society operating under Chapter 10 of this code;

(D) a stipulated premium insurance company operating under Chapter 22 of this code;

(E) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(F) a multiple employer welfare arrangement subject to regulation under Subchapter I, Chapter 3 of this code; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this article applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section

5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1367.052. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.051. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

(b) This article does not apply to:
(1) a plan that provides coverage:
(A) only for a specified disease or other limited benefit;
(B) only for accidental death or dismemberment;
(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(D) as a supplement to liability insurance;
(E) for credit insurance;
(F) only for dental or vision care; or
(G) only for indemnity for hospital confinement;
(2) a small employer health benefit plan written under Chapter 26 of this code;
(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
(4) workers' compensation insurance coverage;
(5) medical payment insurance issued as part of a motor vehicle insurance policy; or
(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide for each covered child from birth through the date of the child's sixth birthday coverage for:

(1) immunization against:

(A) diphtheria;

(B) haemophilus influenzae type b;

(C) hepatitis B;

(D) measles;

(E) mumps;

(F) pertussis;

(G) polio;

(H) rubella;

(I) tetanus; and

(J) varicella; and

(2) any other immunization that is required for the child by law.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for immunization against rotovirus. (V.T.I.C. Art. 20A.09F; Art. 21.53F, Secs. 3, 5, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Art. 20A.09F. In addition to an immunization required under Section 3(a), Article 21.53F, Insurance Code, each health maintenance organization shall include in each health care plan provided by the organization coverage for immunization against rotovirus and any other immunization required for a child by statute or rule.

[Art. 21.53F]

Sec. 3. A health benefit plan that provides benefits for a family member of the insured shall provide coverage for each covered child described by Section 5 of this article, from birth through the date the child is six years of age, for:

(1) immunization against:

(A) diphtheria;

(B) haemophilus influenzae type b;

(C) hepatitis B;

(D) measles;

(E) mumps;

(F) pertussis;

(G) polio;

(H) rubella;

(I) tetanus; and

(J) varicella; and

(2) any other immunization that is required by law for the child.

Sec. 5. A child is entitled to benefits under this article if the child, as a result of the child's relationship to an enrollee in the health benefit plan, would be entitled to benefits under an accident and sickness insurance policy under Subsection (K), (L), or (M), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code).

Revisor's Note

(1) V.T.I.C. Article 20A.09F requires a health maintenance organization to provide coverage for any immunization required for a child by "statute or rule." The revised law substitutes "law" for "statute or rule" because in context "law" is synonymous with "statute or rule" and "law" is the more commonly used term.

(2) Section 3, V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to coverage for a family member of the "insured." "Insured" is a term used in conjunction with traditional insurance. This subchapter also applies to health benefit plans offered by entities such as health maintenance organizations that are not insurers. In relation to those plans, "enrollee" is a more accurate term than "insured," and the revised law consequently adds a reference to "enrollee."

Revised Law

Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENT PROHIBITED. (a) Coverage required under Section 1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement.

(b) This section does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S.,

Ch. 683.)

Source Law

Sec. 6. (a) Benefits required under Section 3 of this article may not be made subject to a deductible, copayment, or coinsurance requirement. This subsection does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time as the immunization.

Revised Law

Sec. 1367.055. RULES. The commissioner may adopt reasonable rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Sec. 7, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Sec. 7. The commissioner may adopt rules as necessary to implement this article.

[Sections 1367.056-1367.100 reserved for expansion]

SUBCHAPTER C. HEARING TEST

Revised Law

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This subchapter applies to a health benefit plan described by Subsection (a) that provides coverage to a resident of this state, regardless of whether the plan issuer is located in or outside this state. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), 4(c) (part), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

> Sec. 2. (a) This article applies only to a health benefit plan that:
>
> (1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
>
> (A) an insurance company;
>
> (B) a group hospital service corporation operating under Chapter 20 of this code;
>
> (C) a fraternal benefit society operating under Chapter 10 of this code;
>
> (D) a stipulated premium insurance company operating under Chapter 22 of this code;
>
> (E) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or
>
> (F) a multiple employer welfare arrangement subject to regulation under Subchapter I, Chapter 3 of this code; or
>
> (2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.
>
> (c) Notwithstanding Section 172.014, Local Government Code, or any other law, this article applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.
>
> [Sec. 4]
>
> (c) This section applies to any health benefit plan that provides coverage or benefits to a resident of this state, without regard to whether the issuer of the health benefit plan is located within or outside

this state. . . .

Revisor's Note

Section 2(a), V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act, and the reference to the commissioner issuing the certificate of authority for the reasons stated in the revisor's note to Section 1367.051.

Revised Law

Sec. 1367.102. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under

a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.101. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:

(1) a screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and

(2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:

(1) employed outside this state; and

(2) covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit. (V.T.I.C. Art. 21.53F, Secs. 4(a), (c) (part), 5, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

> Sec. 4. (a) A health benefit plan that provides benefits for a family member of the insured shall provide coverage for each covered child described by Section 5 of this article for:
>
> (1) a screening test for hearing loss from birth through the date the child is 30 days old, as provided by Chapter 47, Health and Safety Code; and
>
> (2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.
>
> (c) . . . This section does not require the issuer of a health benefit plan to provide coverage under this section for the child of a resident of this state who:
>
> (1) is employed outside of this state; and
>
> (2) is covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.
>
> Sec. 5. A child is entitled to benefits under this article if the child, as a result of the child's relationship to an enrollee in the health benefit plan, would be entitled to benefits under an accident and sickness insurance policy under Subsection (K), (L), or (M), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code).

Revisor's Note

Section 4(a), V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to coverage for a family member of the "insured." The revised law adds a reference to

"enrollee" for the reason stated in Revisor's Note (2) to Section 1367.053.

Revised Law

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED. (a) Coverage required under this subchapter:

(1) may be subject to a copayment or coinsurance requirement; and

(2) may not be subject to a deductible requirement or a dollar limit.

(b) The requirements of this section must be stated in the coverage document. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

(b) Benefits required under Section 4 of this article may be subject to copayment and coinsurance requirements, but may not be subject to a deductible requirement or dollar limit. The requirements of this subsection must be stated in the coverage document.

Revised Law

Sec. 1367.105. RULES. The commissioner may adopt rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Secs. 4(b), 7, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

[Sec. 4]

(b) The commissioner may adopt rules to implement the requirement of this section.

Sec. 7. The commissioner may adopt rules as necessary to implement this article.

[Sections 1367.106-1367.150 reserved for expansion]

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Revised Law

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53W, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service

corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53W, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 2(a), V.T.I.C. Article 21.53W, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act, and the reference to the commissioner issuing the certificate of authority for the reasons stated in the revisor's note to Section 1367.051.

Revised Law

Sec. 1367.152. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement or other hospital expenses;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.151. (V.T.I.C. Art. 21.53W, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement or other hospital expenses;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. (V.T.I.C. Art. 21.53W, Sec. 3.)

Source Law

Sec. 3. A health benefit plan that provides benefits to a child who is younger than 18 years of age must define reconstructive surgery for craniofacial abnormalities under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Revised Law

Sec. 1367.154. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.53W, Sec. 4.)

Source Law

Sec. 4. The commissioner shall adopt rules as necessary to administer this article.

Revisor's Note
(End of Subchapter)

(1) Section 1(1), V.T.I.C. Article 21.53W, defines "enrollee." The revised law omits the definition as unnecessary because the defined term is not used in the revision of Article 21.53W. The omitted law reads:

> Art. 21.53W
> Sec. 1. In this article:
> (1) "Enrollee" means an individual enrolled in a health benefit plan.

(2) Section 1(2), V.T.I.C. Article 21.53W, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1367.151 and 1367.152, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (2) "Health benefit plan" means a plan described by Section 2(a) of this article.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1367.051, 1367.052, 1367.101, and 1367.102, specify the types of health benefit plans to which Subchapters B and C apply, and thus the defined term is not helpful to the reader. The omitted law reads:

> Art. 21.53F
> Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Revised Law

Sec. 1368.001. DEFINITIONS. In this chapter:

(1) "Chemical dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.

(2) "Chemical dependency treatment center" means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:

(A) affiliated with a hospital under a contractual agreement with an established system for patient referral;

(B) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;

(C) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(D) licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.

(3) "Controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481,

Health and Safety Code. (V.T.I.C. Art. 3.51-9, Secs. 2, 2A(e).)

Source Law

Sec. 2. In this article:

(1) "Chemical dependency" means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

(2) "Controlled substance" means a toxic inhalant or a substance designated as a controlled substance in the Chapter 481, Health and Safety Code.

(3) "Toxic inhalant" means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.

[Sec. 2A]

(e) For purposes of this section, the term "chemical dependency treatment center" means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

(1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or

(2) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

(3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(4) licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Revisor's Note

(1) Section 2(3), V.T.I.C. Article 3.51-9, defines "toxic inhalant" to mean a volatile chemical under Chapter 484, Health and Safety Code, or an abusable glue or aerosol paint under Section 485.001, Health and Safety Code. Chapter 459, Acts of the 77th Legislature, Regular Session, 2001, amended Section 484.002, Health and Safety Code, which designates certain chemicals as volatile chemicals. However, Chapter 1463, Acts of the 77th Legislature, Regular Session, 2001, repealed Chapter 484, Health and Safety Code, and amended Section 485.001, Health and Safety Code, by substituting the term "abusable volatile chemical" for the defined term "abusable glue or aerosol paint." Section 311.025, Government Code (Code Construction Act), provides that "[i]f the

amendments [to the same statute enacted in the same session of the legislature] are irreconcilable, the latest in date of enactment prevails" and further provides a method for determining the latest in date of enactment. Under this method, Chapter 1463 prevails over Chapter 459. Consequently, the revised law substitutes "abusable volatile chemical as defined by Section 485.001, Health and Safety Code," for "toxic inhalant" and the definition of "toxic inhalant" provided by Section 2(3), V.T.I.C. Article 3.51-9. In addition, the revised law incorporates the substance of the definition of "abusable volatile chemical" into the definition of "controlled substance" provided by Section 2(2), V.T.I.C. Article 3.51-9, revised as Section 1368.001(3), because that is the only other use of the term "toxic inhalant," revised as "abusable volatile chemical," in V.T.I.C. Article 3.51-9.

(2) Section 2A(e)(2), V.T.I.C. Article 3.51-9, refers to the "Joint Commission on Accreditation of Hospitals." The proper name of that organization is the Joint Commission on Accreditation of Healthcare Organizations. The revised law is drafted accordingly.

(3) Section 2A(e)(4), V.T.I.C. Article 3.51-9, refers to a facility licensed, certified, or approved as a chemical dependency treatment program or center by a state agency "having legal authority to so license, certify, or approve." The revised law omits the quoted language as unnecessary because only an authorized agency may effectively license, certify, or approve a treatment program or center.

Revised Law

Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital

and medical coverage or services on an expense incurred, service, or prepaid basis, including a group insurance policy or contract or self-funded or self-insured plan or arrangement that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; or

(4) an employer, trustee, or other self-funded or self-insured plan or arrangement. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Source Law

> Sec. 2A. (a) Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state . . . under such group insurance policies or contracts and such plans or arrangements providing hospital and medical coverage or services on an expense incurred, service, or prepaid basis . . . .

Revisor's Note

> Section 2A(a), V.T.I.C. Article 3.51-9, refers to "nonprofit hospital and medical service plan corporations" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to describe such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "nonprofit hospital and medical service plan corporations" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1368.003. EXCEPTION. This chapter does not apply to:

(1) an employer, trustee, or other self-funded or self-insured plan or arrangement with 250 or fewer employees or

members;

(2) an individual insurance policy;

(3) an individual evidence of coverage issued by a health maintenance organization;

(4) a health insurance policy that provides only:

(A) cash indemnity for hospital or other confinement benefits;

(B) supplemental or limited benefit coverage;

(C) coverage for specified diseases or accidents;

(D) disability income coverage; or

(E) any combination of those benefits or coverages;

(5) a blanket insurance policy;

(6) a short-term travel insurance policy;

(7) an accident-only insurance policy;

(8) a limited or specified disease insurance policy;

(9) an individual conversion insurance policy or contract;

(10) a policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or

(11) an evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date. (V.T.I.C. Art. 3.51-9, Secs. 2A(c), 3 (part).)

Source Law

[Sec. 2A]

(c) This section does not apply to any employer, trustee, or any other self-funded or self-insured plans or arrangements with 250 or fewer employees or members, or any individual insurance policies regardless of the method of solicitation or sale, or any individual H.M.O. policies, or to any health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability

income coverage, or any combination thereof.

Sec. 3. This Act applies to group policies or contracts or coverage provided by health maintenance organizations delivered or issued for delivery or renewed, extended, or amended in this state on or after January 1, 1982, or upon the expiration of a collective bargaining agreement applicable to a particular policyholder, whichever is later; provided that this Act does not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans. . . .

Revisor's Note

(1) Section 2A(c), V.T.I.C. Article 3.51-9, provides that the section does not apply to "any individual insurance policies regardless of the method of solicitation or sale." The revised law omits "regardless of the method of solicitation or sale" because, in context, it is unnecessary and does not add to the clear meaning of the law. A policy is either an individual policy or it is not, and the method of solicitation or sale is irrelevant to that determination.

(2) Section 2A(c), V.T.I.C. Article 3.51-9, refers to health maintenance organization "policies." The term most frequently used to describe the type of coverage document issued by a health maintenance organization is "evidence of coverage." Consequently, the revised law substitutes "evidence of coverage" for "policies" to provide for consistent use of terminology throughout this code. Comparable changes have been made throughout this chapter.

(3) Section 3, V.T.I.C. Article 3.51-9, provides that the article applies to "group policies or contracts or coverage provided by health maintenance organizations delivered or issued for delivery or renewed, extended, or amended in this

state on or after January 1, 1982." The revised law omits the provision as obsolete; any policy or contract now in effect would have been delivered, issued, renewed, extended, or amended on or after January 1, 1982.

(4) Section 3, V.T.I.C. Article 3.51-9, refers to "Title XVIII of the Social Security Act, known as Medicare." The revised law omits the reference to "Title XVIII of the Social Security Act" as unnecessary because "Medicare" is commonly used in other statutes of the state without an accompanying citation, and its meaning is unambiguous.

Revised Law

Sec. 1368.004. COVERAGE REQUIRED. (a) A group health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.

(b) Coverage required under this section may be provided:

(1) directly by the group health benefit plan issuer; or

(2) by another entity, including a single service health maintenance organization, under contract with the group health benefit plan issuer. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Source Law

> (a) [Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state] shall provide, directly or by contract with other entities, including a single service health maintenance organization, . . . benefits for the necessary care and treatment of chemical dependency . . . .

Revised Law

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except as provided by Subsection (b), coverage required under this

chapter:

(1) may not be less favorable than coverage provided for physical illness generally under the plan; and

(2) shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors that apply to coverage provided for physical illness generally under the plan.

(b) A group health benefit plan may set dollar or durational limits for coverage required under this chapter that are less favorable than for coverage provided for physical illness generally under the plan if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Section 1368.007. If guidelines and standards adopted under Section 1368.007 are not in effect, the dollar and durational limits may not be less favorable than for physical illness generally.

(c) This section does not require payment of a usual, customary, and reasonable rate for treatment of a covered individual if a health maintenance organization or preferred provider organization establishes a negotiated rate for the locality in which the covered individual customarily receives care.

(V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Source Law

> (a) [Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state shall provide] . . . benefits for the necessary care and treatment of chemical dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors. An entity under this section may set dollar or durational limits in a policy, contract, plan, or arrangement providing benefits under this article which are less favorable than for physical illness generally if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Subsection (d) of this section.
>
> This section shall not be construed to require that a usual, customary, and reasonable rate be paid when a negotiated rate is established by a health maintenance organization or preferred provider

organization for the locality in which the covered individual customarily receives care.

If no guidelines or standards are in effect under Subsection (d), such limits shall be no less favorable than for physical illness generally.

Revised Law

Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this section, "treatment series" means a planned, structured, and organized program to promote chemical-free status that:

(1) may include different facilities or modalities; and

(2) is completed when the covered individual:

(A) is, on medical advice, discharged from:

(i) inpatient detoxification;

(ii) inpatient rehabilitation or treatment;

(iii) partial hospitalization or intensive outpatient treatment; or

(iv) a series of those levels of treatments without a lapse in treatment; or

(B) fails to materially comply with the treatment program for a period of 30 days.

(b) Notwithstanding Section 1368.005, coverage required under this chapter is limited to a lifetime maximum of three separate treatment series for each covered individual. (V.T.I.C. Art. 3.51-9, Sec. 2A(b).)

Source Law

(b) Notwithstanding Subsection (a) of this section, coverage for chemical dependency is limited to a lifetime maximum of three separate series of treatments for each covered individual.

A series of treatments is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered individual is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

Revised Law

Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided

under this chapter for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital.

(b) The department by rule shall adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers.

(c) Standards adopted under this section must provide for:

(1) reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods; and

(2) appropriate utilization review of treatment as well as necessary extensions of treatment.

(d) Coverage required under this chapter is subject to the standards adopted under this section. (V.T.I.C. Art. 3.51-9, Sec. 2A(d).)

Source Law

> (d) Any benefits so provided shall be determined as if necessary care and treatment in a chemical dependency treatment center were care and treatment in a hospital. The Texas Department of Insurance and the Texas Commission on Alcohol and Drug Abuse shall formulate standards for use by insurers, other third party reimbursement sources, and chemical dependency treatment centers for the reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods. The standards shall provide for appropriate utilization review of treatment as well as necessary extensions of treatment. The department by rule shall adopt the standards as approved by both the department and the Texas Commission on Alcohol and Drug Abuse, and those standards are applicable to the provision of all services under this section. On adoption of standards or rules by the department under this section, benefits provided herein shall be subject to those standards or rules.

Revisor's Note

Section 2A(d), V.T.I.C. Article 3.51-9, provides that the "services" and "benefits" provided under that section are subject to certain standards adopted by the Texas Department of Insurance. The revised law substitutes "coverage" for "services" and "benefits"

to provide for consistent use of terminology throughout this chapter.

Revised Law

Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH CHAPTER. A group health benefit plan issuer that uses a policy form approved by the commissioner before November 10, 1981, may use an endorsement or rider to comply with this chapter if the endorsement or rider is approved by the commissioner as complying with this chapter and other provisions of this code. (V.T.I.C. Art. 3.51-9, Sec. 3 (part).)

Source Law

> Sec. 3. . . . With respect to any policy forms approved by the State Board of Insurance prior to the effective date of this Act, an insurer is authorized to achieve compliance with this Act by the use of endorsements or riders provided such endorsements or riders are approved by the State Board of Insurance as being in compliance with this Act and other provisions of the Texas Insurance Code.

Revisor's Note

(1) Section 3, V.T.I.C. Article 3.51-9, refers to the "State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The reference to the State Board of Insurance has been changed appropriately.

(2) Section 3, V.T.I.C. Article 3.51-9, refers to an "insurer." The revised law substitutes "group health benefit plan issuer" for "insurer" to provide for consistent use of terminology throughout this chapter.

(3) Section 3, V.T.I.C. Article 3.51-9, refers to "the effective date of this Act." The effective date of the act that added that section is November 10, 1981. Consequently, the revised law substitutes

"November 10, 1981," for the quoted language.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 3.51-9, states the purpose of that article. The revised law omits the provision as unnecessary because it is nonsubstantive and because the legislative purpose in enacting the article is clear from the other, substantive provisions of the article revised in this chapter. The omitted law reads:

> Art. 3.51-9
> Sec. 1. The purpose of this article is to provide consumers with benefits for the care and treatment of chemical dependency in group health insurance policies or contracts, group health coverage provided by health maintenance organizations, and all self-funded or self-insured plans (but excluding those self-funded or self-insured plans with 250 or fewer employees or members), that provide basic hospital, surgical, or major medical expense benefits or coverages or any combination of these coverages, but excluding all individual insurance policies, and any individual H.M.O. policies, regardless of the method of solicitation or sale, and excluding all health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability income coverage, or any combination thereof.

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

[Sections 1369.006-1369.050 reserved for expansion]